NICE National Institute for Health and Care Excellence

NICE guideline

Long-acting reversible contraception

Clinical guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline is the basis of QS129.

Overview

This guideline covers long-acting reversible contraception. It aims to increase the use of long-action reversible contraception by improving the information given to women about their contraceptive choices.

In March 2019 we revised our decision on how to implement the recommendations of our October 2017 review. Although no new evidence was identified, we noted significant changes in how we commission and provide contraceptive services in England. We have removed the recommendations in this guideline that no longer fit with current practice. There are also many new LARC products now available. See our long-acting reversible contraception: implementation resource summary for links to the latest information.

Who is it for?

- Healthcare professionals
- Commissioners and providers
- Women who need contraception and their partners, families and carers

Introduction

It is estimated that about 30% of pregnancies are unplanned. The effectiveness of the barrier method and oral contraceptive pills depends on their correct and consistent use. By contrast, the effectiveness of long-acting reversible contraceptive (LARC) methods does not depend on daily concordance. The uptake of LARC is low in Great Britain, at around 12% of women aged 16–49 in 2008–09, compared with 25% for the oral contraceptive pill and 25% for male condoms.

Expert clinical opinion is that LARC methods may have a wider role in contraception and their increased uptake could help to reduce unintended pregnancy. The current limited use of LARC suggests that healthcare professionals need better guidance and training so that they can help women make an informed choice. Health providers and commissioners also need a clear understanding of the relative cost effectiveness of LARC compared with other methods of fertility control. Enabling women to make an informed choice about LARC and addressing women's preferences is an important objective of this guideline.

LARC is defined in this guideline as contraceptive methods that require administration less than once per cycle or month. Included in the category of LARC are:

- copper intrauterine devices
- progestogen-only intrauterine systems
- progestogen-only injectable contraceptives
- progestogen-only subdermal implants

The guideline offers the best-practice advice for all women of reproductive age who may wish to regulate their fertility by using LARC methods. It covers specific issues for the use of these methods during the menarche and before the menopause, and by particular groups, including women who have HIV, learning disabilities or physical disabilities, or are younger than 16 years.

Drug recommendations

The guideline will assume that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients.

Woman-centred care

This guideline offers the best-practice advice on the provision of information and care for women who are considering or using LARC. Treatment and care should take into account women's individual needs and preferences.

Women who are considering using or who use LARC, and healthcare professionals, have rights and responsibilities as set out in the NHS Constitution for England – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences. Women should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If the patient is under 16, their family or carers should also be given information and support to help the child or young person to make decisions about their treatment. Healthcare professionals should follow the Department of Health's advice on consent. If someone does not have capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

NICE has produced guidance on the components of good patient experience in adult NHS services. All healthcare professionals should follow the recommendations in patient experience in adult NHS services.

1 Recommendations

1.1 Contraception and principles of care

1.1.1 Contraceptive provision

1.1.1.1 Women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods.

1.1.1.2 Women should be provided with the method of contraception that is most acceptable to them, provided it is not contraindicated.

1.1.1.3 Contraceptive service providers should be aware that:

- all currently available LARC methods (intrauterine devices [IUDs], intrauterine systems[1] [IUSs], injectable contraceptives and implants) are more cost effective than the combined oral contraceptive pill even at 1 year of use
- IUDs, IUSs and implants are more cost effective than the injectable contraceptives
- increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies.

1.1.2 Provision of information and informed choice

1.1.2.1 Women considering LARC methods should receive detailed information – both verbal and written – that will enable them to choose a method and use it effectively. This information should take into consideration their individual needs and should include:

- contraceptive efficacy
- duration of use
- risks and possible side effects
- non-contraceptive benefits
- the procedure for initiation and removal/discontinuation

- when to seek help while using the method.

  See the implementation resource, which provides links to up to date, relevant and valid information about LARC methods.

1.1.2.2 Counselling about contraception should be sensitive to cultural differences and religious beliefs.

1.1.2.3 Healthcare professionals should have access to trained interpreters for women who are not English speaking, and to advocates for women with sensory impairments or learning disabilities.

1.1.3 Contraceptive prescribing

1.1.3.1 A medical history – including relevant family, menstrual, contraceptive and sexual history – should be taken as part of the routine assessment of medical eligibility for individual contraceptive methods.

1.1.3.2 Healthcare professionals helping women to make contraceptive choices should be familiar with nationally agreed guidance on medical eligibility and recommendations for contraceptive use.

1.1.3.3 When considering choice of LARC methods for specific groups of women and women with medical conditions, healthcare professionals should be aware of and discuss with each woman any issues that might affect her choice (see the implementation resource, which provides links to up to date, relevant and valid information about LARC methods).

1.1.3.4 Healthcare professionals should exclude pregnancy by taking menstrual and sexual history before initiating any contraceptive methods.

1.1.3.5 Healthcare professionals should supply an interim method of contraception at first appointment if required.

1.1.3.6 Healthcare professionals should ensure that informed consent is obtained from the woman whenever any method of LARC is being used outside the terms of the UK Marketing Authorisation. This should be discussed and documented in the notes.

1.1.3.7 Women who have a current venous thromboembolism (VTE) and need hormonal contraception while having treatment for the VTE should be referred to a specialist in contraceptive care.

1.1.4 Contraception and sexually transmitted infection

1.1.4.1 Healthcare professionals providing contraceptive advice should promote safer sex.

1.1.4.2 Healthcare professionals providing contraceptive advice should be able to assess risk for sexually transmitted infections (STIs) and advise testing when appropriate.

1.1.4.3 Healthcare professionals should be able to provide information about local services for STI screening, investigation and treatment.

1.1.5 Contraception for special groups

1.1.5.1 Healthcare professionals should be aware of the law relating to the provision of advice and contraception for young people and for people with learning disabilities. Child protection issues and the Fraser guidelines should be considered when providing contraception for women younger than 16 years[2].

1.1.5.2 Women with learning and/or physical disabilities should be supported in making their own decisions about contraception.

1.1.5.3 Contraception should be seen in terms of the needs of the individual rather than in terms of relieving the anxieties of carers or relatives.

1.1.5.4 When a woman with a learning disability is unable to understand and 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.

1.1.6 Training of healthcare professionals in contraceptive care

1.1.6.1 Healthcare professionals advising women about contraceptive choices should be competent to:

- help women to consider and compare the risks and benefits of all methods relevant to their individual needs
- manage common side effects and problems.

1.1.6.2 Contraceptive service providers who do not provide LARC in their practice or service should have an agreed mechanism in place for referring women for LARC.

1.1.6.3 Healthcare professionals providing intrauterine or subdermal contraceptives should receive training to develop and maintain the relevant skills to provide these methods.

1.1.6.4 IUDs and the IUS should only be fitted by trained personnel with continuing experience of inserting at least one IUD or one IUS a month.

1.1.6.5 Contraceptive implants should be inserted and removed only by healthcare professionals trained in the procedure.

More information

You can also see this guideline in the NICE Pathway on long-acting reversible contraception.

To find out what NICE has said on topics related to this guideline, see our web page on contraception.

See also the guideline committee's discussion and the evidence reviews (in the full guideline), and information about how the guideline was developed, including details of the committee.

[1] The MHRA issued a Drug Safety Update in January 2016 highlighting that levonorgestrel-releasing intrauterine systems should always be prescribed by brand name because products have different indications, durations of use, and introducers.

[2] See the Department of Health's Best practice guidance for doctors and other healthcare professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health (July 2004).

2 Research recommendations

The scarcity of robust evidence to answer important clinical questions on the use of LARC methods by women in the UK posed great challenges to the developers of the original guideline (October, 2005). In the majority of cases, the guideline recommendations were based on extrapolated evidence that is indirect or of poor methodological quality. In 2005, the Guideline Development Group made the following recommendations for research on the basis of its review of the evidence.

In making these recommendations for research, the guideline developers consider it important and relevant that the research should be specific to the UK population because there are cultural differences in the response to side effects and non-contraceptive effects of hormonal contraceptives. In addition, freedom to choose any contraceptive method and the provision of a free contraceptive health service in the UK can influence important outcomes such as continuation rates and patterns of method switching.

2.1 Typical use of contraception

Few women use contraception perfectly (that is, exactly in accordance with the product instructions) and consistently. Pregnancy rates during typical use reflect effectiveness of a method among women who use the method incorrectly or inconsistently. Few data are available on typical use of any contraceptive method among women in the UK. Much of the data on contraceptive effectiveness used in the guideline come from clinical trials or surveys undertaken in other countries such as the USA. Large prospective cohort studies are needed to compare the contraceptive effectiveness of LARC methods with non-LARC methods during typical use in the UK.

2.2 Patterns of LARC use

Most women will need to use contraception for more than 30 years. Patterns of contraceptive use vary with age, ethnicity, marital status, fertility intention, education and lifestyle. Large prospective cohort studies are needed to identify:

- patterns of use (initiation, continuation and switching between methods) of LARC methods compared with non-LARC methods
- factors that influence the patterns of use of LARC.

2.3 Uptake and acceptance of LARC

In addition to individual circumstances and needs, a woman's choice and acceptance of LARC may be influenced by potential health disbenefits (side effects and risks) as well as non-contraceptive benefits of LARC (such as alleviation of menorrhagia). Large population studies of appropriate design are needed to determine the effect of these factors on the uptake of LARC methods and the implications for NHS resources.

2.4 Bone mineral density in women using DMPA

The effect of injectable contraceptives on bone mineral density in women who have used DMPA for longer than 2 years is uncertain. Adequately powered surveys or cross-sectional studies are needed to examine the recovery of bone mineral density after discontinuation of DMPA after long-term and very long-term use. Studies are also needed to examine the risk of bone fractures in older women.

Update information

July 2019: In March 2019 we revised our decision on how to implement the recommendations of our October 2017 review. Although no new evidence was identified, we noted significant changes in how we commission and provide contraceptive services in England. We have removed the recommendations in this guideline that no longer fit with current practice. There are also many new LARC products now available. See our Long-acting reversible contraception: implementation resource summary for links to the latest information.

September 2014: We reviewed the evidence for progestogen-only subdermal implants and updated the recommendations in section 1.5.

Minor changes since publication

August 2015: The definition of long-acting reversible contraception has been corrected, by removing mention of combined vaginal rings. The recommendations do not cover combined vaginal rings.

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