

Contraception

Quality standard

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Contents

Quality statements	4
Quality statement 1: Contraceptive information and methods	5
Quality statement.....	5
Rationale	5
Quality measures.....	5
What the quality statement means for different audiences.....	7
Source guidance.....	7
Definitions of terms used in this quality statement	8
Equality and diversity considerations	10
Quality statement 2: Emergency contraception.....	11
Quality statement.....	11
Rationale	11
Quality measures.....	11
What the quality statement means for different audiences.....	12
Source guidance.....	13
Definitions of terms used in this quality statement	13
Equality and diversity considerations	14
Quality statement 3: Contraception after an abortion.....	15
Quality statement.....	15
Rationale	15
Quality measures.....	15
What the quality statement means for different audiences.....	17
Source guidance.....	17
Definitions of terms used in this quality statement	18
Equality and diversity considerations	19
Quality statement 4: Contraception after childbirth.....	20
Quality statement.....	20

Rationale	20
Quality measures.....	20
What the quality statement means for different audiences.....	21
Source guidance.....	22
Definitions of terms used in this quality statement	22
Equality and diversity considerations	24
Update information	25
About this quality standard	26
Improving outcomes	27
Resource impact.....	27
Diversity, equality and language.....	27

This standard is based on PH51, CG30, NG140 and NG194.

This standard should be read in conjunction with QS115, QS37, QS178, QS157, QS69, QS192, QS196 and QS199.

Quality statements

Statement 1 Women asking for contraception from contraceptive services are given information about, and offered a choice of, all methods including long-acting reversible contraception.

Statement 2 Women asking for emergency contraception are told that an intrauterine device is more effective than an oral method.

Statement 3 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.

Statement 4 Women who give birth are given information about, and offered a choice of, all contraceptive methods by their midwife.

Quality statement 1: Contraceptive information and methods

Quality statement

Women asking for contraception from contraceptive services are given information about, and offered a choice of, all methods including long-acting reversible contraception.

Rationale

Offering information about the full range of contraceptives available, including long-acting reversible contraception, will ensure women asking for routine or emergency contraception can make an informed choice. Helping women choose the method of contraception that suits them best and increasing their awareness of how to use contraceptives effectively, will help to reduce unplanned pregnancies.

Quality measures

Structure

a) Evidence that accessible information is available about the full range of contraceptive methods, including long-acting reversible contraception, and the local services that provide them.

Data source: Local data collection.

b) Evidence of local processes and referral pathways to ensure that women asking for contraception from contraceptive services are given information about, and offered a choice of, all methods including long-acting reversible contraception.

Data source: Local data collection.

Process

a) Proportion of women who ask for contraception from contraceptive services who are given information about all methods, including long-acting reversible contraception.

Numerator – the number in the denominator who are given information about all methods, including long-acting reversible contraception.

Denominator – the number of women who ask for contraception from contraceptive services.

Data source: Local data collection.

b) Proportion of women who ask for contraception from contraceptive services who are offered a choice of all contraceptive methods, including long-acting reversible contraception.

Numerator – the number in the denominator who are offered a choice of all contraceptive methods, including long-acting reversible contraception.

Denominator – the number of women who ask for contraception from contraceptive services.

Data source: Local data collection.

Outcome

a) Contraceptive use in women.

Data source: Local data collection.

b) Uptake of long-acting reversible contraception.

Data source: Local data collection.

c) Women's satisfaction with their choice of contraceptive method.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (including GPs, community pharmacies and sexual and reproductive health services) ensure that ensure that processes are in place to offer women information about, and a choice of, all contraceptive methods, including long-acting reversible contraception. Service providers work together so that they can refer women to a suitable alternative service if they cannot provide the preferred method of contraception.

Healthcare practitioners (including GPs, community pharmacists, sexual and reproductive health consultants and nurses) ensure that they give women who ask for contraception information about, and a choice of, all contraceptive methods, including long-acting reversible contraception. If they cannot provide the woman's preferred method of contraception, they refer them to a suitable alternative service.

Commissioners (clinical commissioning groups, local authorities and NHS England) commission contraceptive services that provide information on all contraceptive methods, including long-acting reversible contraception, and offer all contraceptive methods to all women. Commissioners ensure providers work together to ensure women are provided with their preferred method of contraception.

Women attending a contraceptive service are offered a choice of all contraceptive methods, including long-acting reversible contraception, and the information they need to decide which method is suitable for them. If the service cannot provide their preferred method of contraception, they tell them where they can get it from.

Source guidance

- [Long-acting reversible contraception. NICE guideline CG30](#) (2005, updated 2019), recommendation 1.1.1.1
- [Contraceptive services for under 25s. NICE guideline PH51](#) (2014), recommendation 3

Definitions of terms used in this quality statement

Contraceptive services

Contraceptive services include those offered in education, GP services, pharmacies, maternity and postnatal care services, walk-in centres, acute and emergency care, and the voluntary and private sectors. This includes open access contraceptive services that are available to everyone and provide walk-in and appointment clinics. [[NICE's guideline on contraceptive services for under 25s](#), recommendation 3, and expert opinion]

Information about contraceptive methods

This information covers all contraceptive methods and includes:

- how the method works
- how to use it
- how it is administered
- insertion and removal (for implants and intrauterine devices)
- suitability
- how long it can be used for
- risks and possible side effects
- failure rate
- non-contraceptive benefits
- when to seek help.

[Adapted from [NICE's guideline on long-acting reversible contraception](#) and expert opinion]

All contraceptive methods

This quality standard focuses on all methods of contraception. These are divided into 3 groups:

Long-acting reversible contraceptives that need administration less than once per month. These are:

- contraceptive implant
- contraceptive injection
- intrauterine system (IUS)
- intrauterine device (IUD).

[Adapted from [NICE's guideline on long-acting reversible contraception](#)]

Methods that depend on the person remembering to take or use them. These include:

- combined vaginal ring
- combined transdermal patch
- combined oral contraception
- progestogen-only pill
- male condom
- female condom
- diaphragm or cap with spermicide
- fertility awareness.

Permanent methods of contraception. These are:

- vasectomy
- female sterilisation.

[Adapted from the [Faculty of Sexual and Reproductive Healthcare guidelines on barrier methods for contraception and STI prevention](#), [fertility awareness methods](#), [progestogen-only pills](#) and [combined hormonal contraception](#)]

Equality and diversity considerations

Contraceptive options may be limited for women with a learning disability or cognitive impairment. Contraceptive services should make it clear to women why specific methods cannot be offered to them.

Age, religion and culture may affect which contraceptive methods the woman considers suitable. When discussing contraception, healthcare practitioners should give information about all methods and allow the woman to choose the one that suits her best.

If a healthcare practitioner's beliefs do not let them supply contraception, they should ensure that the woman can see another practitioner as soon as possible.

Quality statement 2: Emergency contraception

Quality statement

Women asking for emergency contraception are told that an intrauterine device is more effective than an oral method.

Rationale

An intrauterine device (IUD) has a lower failure rate than oral methods of emergency contraception. Also, once in place, it can be used on an ongoing basis. If women use an IUD this will reduce the risk of unplanned pregnancies and avoid the need for emergency contraception. If a woman chooses to have an IUD as a form of emergency contraception, but the healthcare practitioner cannot fit it there and then, they should direct the woman to a suitable service and give her an oral method in the interim.

Quality measures

Structure

Evidence of local processes to ensure that women asking for emergency contraception are told that an intrauterine device is more effective than an oral method.

Data source: Local data collection.

Process

Proportion of requests for emergency contraception where the woman is told that an intrauterine device is more effective than an oral method.

Numerator – the number in the denominator where the woman is told that an intrauterine device is more effective than an oral method.

Denominator – the number of requests for emergency contraception.

Data source: Local data collection. NHS Quality and Outcomes Framework indicator CON003 captured data on the provision of information about long-acting reversible methods of contraception to women who are prescribed emergency hormonal contraception by their GP (until 2019).

Outcome

a) Intrauterine device use as an emergency contraceptive.

Data source: Local data collection. [NHS Digital's Sexual and Reproductive Health Activity Dataset](#) includes information on methods of contraception for people using dedicated sexual and reproductive health services.

b) Abortion rate.

Data source: Local data collection. The [Department of Health and Social Care's Abortion statistics](#) can be analysed geographically.

What the quality statement means for different audiences

Service providers (including GPs, community pharmacies and sexual and reproductive health services) ensure that protocols and procedures are in place to tell women asking for emergency contraception that an IUD is more effective than an oral method. Service providers ensure that rapid referral pathways are in place for women who choose an emergency IUD if they are not able to fit one immediately. Service providers also ensure that protocols are in place to offer them an oral emergency method in the interim.

Healthcare practitioners (including GPs, community pharmacists, sexual health consultants and nurses) tell women who ask for emergency contraception that an IUD is more effective than an oral method. Practitioners unable to fit IUDs at presentation refer women to a service that can and offer them an oral emergency method in the interim.

Commissioners (clinical commissioning groups, local authorities and NHS England) ensure that services providing emergency contraception tell women that an IUD is more effective

than an oral method. Commissioners ensure that referral pathways are in place for women who choose to have an emergency IUD fitted if the service cannot provide this on presentation, and that the service offers an oral emergency method in the interim.

Women asking for emergency contraception are told that an intrauterine device (IUD, also known as the coil) is more effective than an oral method (an emergency pill) and can also be used as a long-term method of contraception.

Source guidance

- [Contraceptive services for under 25s. NICE guideline PH51 \(2014\), recommendation 9](#)
- [Emergency contraception. Faculty of Sexual and Reproductive Healthcare guideline \(2017, updated 2020\), section 8](#)

Definitions of terms used in this quality statement

Emergency contraception

If a woman has had sex without using contraception, or thinks that her contraception did not work, an emergency contraceptive can be used. There are 3 different types:

- emergency contraceptive pill, levonorgestrel 1.5 mg
- emergency contraceptive pill, ulipristal acetate 30 mg
- copper intrauterine device.

Both emergency contraceptive pills are also referred to as the 'morning after pill'. [Adapted from the [Faculty of Sexual and Reproductive Healthcare's guideline on emergency contraception](#)]

Intrauterine device

Also referred to as an IUD or coil, this is a small, T-shaped copper device that is inserted in the uterus. It has 1 or 2 threads on the end that hang through the entrance of the uterus (the cervix). In addition to ongoing contraception, the IUD can be used for emergency contraception. [Adapted from the [Faculty of Sexual and Reproductive Healthcare's](#)

[guideline on intrauterine contraception](#)]

Equality and diversity considerations

Age, religion and culture may affect which contraceptive methods the woman considers suitable. When discussing contraception, healthcare practitioners should give information and allow the woman to choose the one that suits her best.

If a healthcare practitioner's beliefs do not let them supply contraception, they should ensure that the woman can see another practitioner as soon as possible.

Quality statement 3: Contraception after an abortion

Quality statement

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.

Rationale

Ensuring women can make an informed choice about contraception following an abortion will reduce the risk of future unplanned pregnancies. Having the opportunity to discuss contraception when they are being assessed for an abortion will give them time to consider all the options. Further discussion before discharge from the abortion service can help ensure timely access to contraception.

Quality measures

Structure

a) Evidence of local processes to ensure that women discuss contraception and all contraceptive methods with a healthcare practitioner when being assessed for an abortion.

Data source: Local data collection.

b) Evidence of local processes to ensure that a healthcare practitioner offers women a choice of all contraceptive methods before discharge from an abortion service.

Data source: Local data collection.

Process

a) Proportion of women who discuss contraception and all contraceptive methods with a healthcare practitioner at an assessment for abortion.

Numerator – the number in the denominator who discuss contraception and all contraceptive methods with a healthcare practitioner.

Denominator – the number of women having an assessment for abortion.

Data source: Local data collection.

b) Proportion of women who are offered a choice of all contraceptive methods before discharge from an abortion service.

Numerator – the number in the denominator who are offered a choice of all contraceptive methods before discharge.

Denominator – the number of women discharged from an abortion service.

Data source: Local data collection.

Outcome

a) Uptake of long-acting reversible contraception at the time of abortion.

Data source: Local data collection.

b) Contraception uptake rate after abortion.

Data source: Local data collection.

c) Women who have more than 1 abortion.

Data source: Local data collection. The [Department of Health and Social Care's Abortion statistics](#) include data on repeat abortions.

What the quality statement means for different audiences

Service providers (including secondary care, community genitourinary medical and private sector services) ensure that establish protocols to ensure that healthcare practitioners discuss contraception and all contraceptive methods with women at their assessment for abortion and before discharge. Service providers offer women a choice of all contraceptive methods before discharge. If contraceptives are not provided at discharge, service providers ensure that referral pathways to a contraceptive service are in place.

Healthcare practitioners (including GPs, hospital doctors and nurses) discuss contraception and all contraceptive methods with women at their assessment for an abortion and before discharge. Healthcare practitioners offer women a choice of all contraceptive methods before discharge. If contraceptives are not provided at discharge, they offer to refer women to a contraceptive service.

Commissioners (clinical commissioning groups) ensure that abortion services discuss contraception and all contraceptive methods with women at their assessment for an abortion and before discharge. Commissioners ensure that abortion services offer women a choice of all contraceptive methods before discharge, or offer a referral to a contraceptive service if contraceptives are not provided. Commissioners could consider a local performance indicator for abortion services to improve uptake of contraception at discharge.

Women who plan to have an abortion are offered the chance to discuss contraception with a healthcare practitioner during assessment for their abortion and again before they are discharged. They are offered a choice of all contraceptive methods before they are discharged or referral to a contraceptive service if contraception is not provided.

Source guidance

- [Contraceptive services for under 25s. NICE guideline PH51 \(2014\)](#), recommendation 7
- [Abortion care. NICE guideline NG140 \(2019\)](#), recommendations 1.2.6 and 1.15.1

Definitions of terms used in this quality statement

Discussion about contraception

When discussing contraception, emphasise that women are fertile immediately after an abortion and give details of all contraceptive methods including:

- how the method works
- how to use it
- how it is administered
- insertion and removal (for implants and IUDs)
- suitability
- how long it can be used for
- risks and possible side effects
- failure rate
- non-contraceptive benefits
- when to seek help.

[Adapted from [NICE's guideline on contraceptive services for under 25s](#), [NICE's guideline on long-acting reversible contraception](#) and expert opinion]

All contraceptive methods

This quality standard focuses on all methods of contraception. These are divided into 3 groups:

Long-acting reversible contraceptives that need administration less than once per month. These are:

- contraceptive implant
- contraceptive injection

- intrauterine system (IUS)
- intrauterine device (IUD).

[Adapted from [NICE's guideline on long-acting reversible contraception](#)]

Methods that depend on the person remembering to take or use them. These include:

- combined vaginal ring
- combined transdermal patch
- combined oral contraception
- progestogen-only pill
- male condom
- female condom
- diaphragm or cap with spermicide
- fertility awareness.

Permanent methods of contraception. These are:

- vasectomy
- female sterilisation.

[Adapted from the [Faculty of Sexual and Reproductive Healthcare guidelines on barrier methods for contraception and STI prevention](#), [fertility awareness methods](#), [progestogen-only pills](#) and [combined hormonal contraception](#)]

Equality and diversity considerations

Age, religion and culture may affect which contraceptive methods the woman considers suitable. When discussing contraception, healthcare practitioners should give information about all methods and allow the woman to choose the one that suits her best.

If a healthcare practitioner's beliefs do not let them supply contraception, they should ensure that the woman can see another practitioner as soon as possible.

Quality statement 4: Contraception after childbirth

Quality statement

Women who give birth are given information about, and offered a choice of, all contraceptive methods by their midwife.

Rationale

Supporting women to make an informed choice about contraception after childbirth will reduce the risk of future unplanned pregnancies. Advice and information should be given as soon as possible after delivery, and within the first week, because fertility may return quickly, including in women who are breastfeeding. Providing advice about contraception after childbirth also helps avoid the risk of complications associated with an interpregnancy interval of less than 12 months.

Quality measures

Structure

a) Evidence of local processes to ensure that women who give birth are given information about all contraceptive methods by their midwife within 7 days of delivery.

Data source: Local data collection.

b) Evidence of local processes and referral pathways to ensure that women who give birth are offered a choice of all contraceptive methods by their midwife within 7 days of delivery.

Data source: Local data collection.

Process

a) Proportion of women who give birth who are given information about all contraceptive methods by their midwife within 7 days of delivery.

Numerator – the number in the denominator who are given information about all contraceptive methods by their midwife within 7 days of delivery.

Denominator – the number of women who give birth.

Data source: Local data collection.

b) Proportion of women who give birth who are offered a choice of all contraceptive methods by their midwife within 7 days of delivery.

Numerator – the number in the denominator who are offered a choice of all contraceptive methods by their midwife within 7 days of delivery.

Denominator – the number of women who give birth.

Data source: Local data collection.

Outcome

a) Satisfaction with advice about contraceptive methods after childbirth.

Data source: Local data collection

b) Contraception uptake rates in women who have given birth.

Data source: Local data collection.

c) Women who have a short interpregnancy interval.

Data source: Local data collection.

What the quality statement means for different

audiences

Service providers (secondary care and community maternity services) establish protocols to ensure that midwives give women information about all contraceptive methods and offer them a choice of all methods, as soon as possible and within 7 days of delivery. Service providers ensure women are referred to a contraceptive service if their chosen contraceptive cannot be provided immediately.

Healthcare practitioners (midwives) give women information about and offer them a choice of all contraceptive methods, as soon as possible and within 7 days of delivery. Midwives refer women to a contraceptive service if their chosen contraceptive cannot be provided immediately.

Commissioners (clinical commissioning groups) ensure that maternity services give women information about and offer them a choice of all contraceptive methods as soon as possible and within 7 days of delivery, and refer them to a contraceptive service if contraception cannot be provided immediately.

Women who give birth are offered a choice of all contraceptive methods and given the information they need to decide which method is suitable for them by their midwife. This happens within a week of delivery. The midwife tells them how to get their chosen contraceptive.

Source guidance

- [Contraceptive services for under 25s. NICE guideline PH51 \(2014\)](#), recommendation 6
- [Contraception after pregnancy. Faculty of Sexual and Reproductive Healthcare guideline \(2017\)](#), section 2.1.1

Definitions of terms used in this quality statement

Information about contraceptive methods

This information covers all contraceptive methods and includes:

- how the method works

- how to use it
- how it is administered
- insertion and removal (for implants and intrauterine devices)
- suitability
- how long it can be used for
- risks and possible side effects
- failure rate
- non-contraceptive benefits
- when to seek help.

[Adapted from [NICE's guideline on long-acting reversible contraception](#) and expert opinion]

All contraceptive methods

This quality standard focuses on all methods of contraception. These are divided into 3 groups:

Long-acting reversible contraceptives that need administration less than once per month. These are:

- contraceptive implant
- contraceptive injection
- intrauterine system (IUS)
- intrauterine device (IUD).

[Adapted from [NICE's guideline on long-acting reversible contraception](#)]

Methods that depend on the person remembering to take or use them. These include:

- combined vaginal ring

- combined transdermal patch
- combined oral contraception
- progestogen-only pill
- male condom
- female condom
- diaphragm or cap with spermicide
- fertility awareness.

Permanent methods of contraception. These are:

- vasectomy
- female sterilisation.

[Adapted from the Faculty of Sexual and Reproductive Healthcare guidelines on barrier methods for contraception and STI prevention, fertility awareness methods, progestogen-only pills and combined hormonal contraception]

Equality and diversity considerations

Age, religion and culture may affect which contraceptive methods the woman considers suitable. When discussing contraception healthcare practitioners should give information about all methods and allow the woman to choose the method that suits her best.

If a healthcare practitioner's beliefs do not let them supply contraception, they should ensure that the woman can see another practitioner as soon as possible.

Update information

Minor changes since publication

April 2021: Changes have been made to align this quality standard with the updated [NICE guideline on postnatal care](#). Statement 4 was updated, and the source guidance reference changed to reflect that a 7-day timescale is no longer included in the NICE guideline.

January 2020: Changes have been made to align this quality standard with the updated [NICE guideline on long-acting reversible contraception](#) and the new [NICE guideline on abortion care](#). Source guidance and definitions have been updated.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See our [webpage on quality standard advisory committees](#) for details of standing committee 2 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

This quality standard has been included in the [NICE Pathways on contraception, abortion care and postnatal care](#), which bring together everything we have said on a topic in an interactive flowchart.

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

- under-18 conceptions
- abortion rate
- women having more than 1 abortion
- accessibility of contraceptive services
- provision of information about contraception
- use of long-acting reversible contraception.

It is also expected to support delivery of the following national frameworks:

- [NHS outcomes framework](#)
- [Public health outcomes framework for England](#).

Equivalent frameworks may be used in the devolved nations.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the [costing report and template for NICE's guideline on contraceptive services for under 25s](#) to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful

discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisations

This quality standard has been endorsed by the following organisations, as required by the Health and Social Care Act (2012):

- [NHS England](#)
- [Department of Health and Social Care](#)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Faculty of Sexual and Reproductive Healthcare](#)
- [Royal College of General Practitioners \(RCGP\)](#)