QUICK STARTING CONTRACEPTION

What's New:

There are no significant changes.

In the specific situation in which an established CHC user restarts CHC after a hormone-free interval and then misses 2-7 pills in the first week of pill-taking (or makes an equivalent error with combined patch or ring use): LNG-EC may be offered, with immediate restart of CHC and use of condoms for 7 days (no change to guidance)
If UPA-EC is preferred, it may be offered, now with immediate restart of CHC and use of condoms for 7 days (new recommendation for this specific scenario only).

The increased efficacy of UPA over LNG must be balanced against the theoretical reduced efficacy of prior progestogen.

Background:

Quick starting (QS) is the immediate initiation of a contraceptive method at the time a person requests it, before the next natural menstrual period. This practice may be outside the product licence of the chosen method, but may have potential benefits such as reducing the time of pregnancy risk, reducing the chance of forgetting information on the chosen method and negating the need for a further appointment.

Any quick start method may be continued as an ongoing method of contraception or can be used as a temporary 'bridging' method until the preferred method is commenced (e.g. pregnancy excluded).

Table 1 - highlights which methods can be quick started when pregnancy is excluded

Table 2 - highlights the additional contraceptive requirements when quick starting contraception. As with all other clients, all contraceptive methods should be discussed and STI risk assessment performed.

QS if pregnancy can be excluded:

Any method of contraception can be quick started at any time in the menstrual cycle if it is reasonably certain that a person is not pregnant or at risk of pregnancy from recent unprotected sexual intercourse (UPSI).

See below:

HCPs can be 'reasonably certain' that a person is not currently pregnant if any one or more of the following criteria are met and there are no symptoms or signs of pregnancy:

No intercourse since last normal (natural) menses, childbirth, abortion, miscarriage, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease.

Correctly and consistently using a reliable method of contraception or
Within the first 5 days of the onset of a normal menstrual period 0r
Less than 21 days post-partum (non-breast feeding people) or
Fully breast feeding, amenorrhoeic and less than 6 months post partum or
Within the first 5 days after abortion, miscarriage, ectopic or uterine evacuation for gestational trophoblastic disease.

No intercourse for >21 days and has a negative high sensitivity urine pregnancy test (HSUPT) (able to detect hcg levels around 20mIU/ml).

QS if pregnancy cannot be excluded.

People who have a negative HSUPT but are at risk of pregnancy from recent UPSI should be advised that:

Emergency contraception may be indicated.

Contraceptive hormones are not thought to cause harm to the fetus and they should not be advised to terminate pregnancy on the grounds of exposure.

Additional contraceptive precautions (barrier or abstinence) are required until the quick started contraceptive method becomes effective. See table 2.

A follow up high sensitivity urinary pregnancy test (HSUPT) is required no sooner than 21 days after the last UPSI. Provide a pregnancy testing kit or inform of alternative options for pregnancy testing, including local providers of free testing.

Offer a supply of condoms or inform of local condom providers
Advise to return if there are any concerns or problems with contraception.

Table 1: Summary of methods which can be quick started when pregnancy cannot be excluded:

Situation	Quick started
CHC	✓
CHC – containing cyproterone acetate	×
POP	✓
PO-Implant	✓
DMPA	Consider if no other method acceptable
LNG-IUS	×
Following LNG-EC: CHC POP PO-Implant DMPA	Immediate QS ✓
Following UPA-EC: CHC* POP PO-Implant DMPA	Delayed Start Wait 5 days (120 hours) before QS method *unless missed pills day 2-7 of COC. Start, and use condoms for 7 days

Table 2: Summary of additional contraceptive requirements when starting contraception.

Method	Circumstances (day of menstrual cycle[a] /method of emergency contraception)	Days of additional contraception required (condoms / avoidance of sex)
	After UPA EC wait at least 5 days before starting hormonal contraception. Advise use of condoms before starting contraception and for 7 days after, as recommended above. *unless days 2-7 missed pill after pill-free week	*condoms for 7 days if starting COC
CHC (except Qlaira® & Zoely®)	Days 1-5 Day 6 onwards / QS after EC[b]	0 7
Zoely® COC	Day 1 Day 2 onwards/ QS after EC[b]	0 7
Qlaira® COC	Day 1 Day 2 onwards/ QS after EC[b]	0 9
Progestogen-only pill (traditional/desogestrel)	Days 1–5 Day 6 onwards / QS after EC[b]	0 2
IMP, DMPA	Days 1–5 Day 6 onwards/ QS after EC[b]	0 7
LNG-IUS	Days 1–7 Day 8 onwards	0 7
Copper IUD	Any start day[d]	0

Day 1 defined as first day of menstrual bleeding; does not apply to withdrawal or unscheduled bleeding in women already established on hormonal contraception.
After UPA EC wait at least 5 days before starting hormonal contraception. Advise use of condoms before starting contraception and for 7 days after, as recommended above
Please refer to the EC protocol if the copper IUD is being inserted as an emergency contraceptive

EC, Emergency Contraception

Pregnancy diagnosed after QS contraception

FSRH Guidance advices that people should be informed that contraceptive hormones are not thought to cause harm to the fetus and they should not be advised to terminate pregnancy on the grounds of exposure.

Wish to continue pregnancy (using CHC, POP, IMP, DMPA)

The method should be removed or stopped, if a pregnancy is diagnosed after starting contraception.

Chose not to continue pregnancy

IMP or DMPA:
They can continue the method of contraception with no additional contraception precautions after abortion. If DMPA administered at time of mifepristone there may be a slightly higher risk of failed medical abortion.

CHC or POP:
They should stop method and restart contraception immediately after abortion with no additional contraception requirements.

Using intrauterine contraception (IUC)

HCPs should advise those whose intrauterine pregnancy is less than 12 weeks gestation that IUC should be removed, as long as the threads are visible or it can be easily removed from the endocervical canal. This is regardless of whether they decide to continue with the pregnancy.
The risk of adverse intrauterine pregnancy events are greater with an IUD in situ compared to those without.

IUD removal in first trimester could improve pregnancy outcomes, but it is associated with a small risk of miscarriage.

Documentation

QS hormonal contraception without being reasonably sure pregnancy is excluded is outside the terms of the product licence, however the FSRH support QS contraception as outlined in their guidance.

Use of products for QS is “off-label” and clinicians should refer to their professional advice and guidance on the necessary counselling and documentation to provide patients. The NHSGGC policy is available at https://ggcmedicines.org.uk/medicines-policies/ under the acute unlicensed medicines section, which includes off-label prescribing.

References

FSRH Quick Starting Contraception. April 2017. Available from: www.fsrh.org/standards-and-guidance/current-clinical-guidance/quick-starting-contraception/ [Accessed June 2025]

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