Non-oral contraceptive options: how to find the right fit

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With an increasing choice of non-oral contraceptives available it is important that patients understand the risks and benefits of each option. Our drug review discusses the properties, efficacy and suitability of currently available non-oral contraceptives.

When a woman consults a health professional for contraceptive advice, she should be offered the full range of options including long-acting reversible contraceptives (LARCs), as specified in NICE CG30, and the advantages and disadvantages of each should be discussed so that she can make an informed choice relating to her own specific needs. This should be supported by written information and a follow-up date so that any further questions can be answered.

The ideal contraceptive is safe, effective, free from side-effects, cost-effective, independent of health professionals, easily available, independent of intercourse and acceptable to all cultures, and should protect against sexually transmitted infections. Unfortunately such a method of contraception does not yet exist but there is a good selection of non-oral options that are highly effective and safe (see Table 1). These can be divided into hormonal and non-hormonal products.

Oral contraceptives are easy to take and under the control of the patient. However, effectiveness depends on correct and consistent use and there is a higher failure rate than with some of the non-oral methods such as LARCs, which are very effective because they are not user dependent. All LARC methods are more cost effective than the combined oral contraceptive (COC) pill because they reduce the likelihood of unplanned pregnancy, and intrauterine methods and implants are more cost effective than injectable contraceptives.

Non-oral contraception such as the vaginal ring, transdermal patch, progestogen-only implant and progestogen-only injectable can also be used for “quick starting” contraception following administration of emergency contraception when a woman is likely to continue to be at risk of pregnancy or has expressed a preference to start contraception without delay.

Contraindications to the non-oral contraceptives are described in the UK Medical Eligibility Criteria (UKMEC) for Contraceptive Use. UKMEC criteria are based on the WHO’s medical eligibility criteria and are as follows:

• UKMEC1 – a condition for which there is no restriction of use of the method
Hormonal options  

*Evra*  

Evra is a transdermal delivery system containing ethinylestradiol and norelgestromin. The hormones are absorbed through the skin via a patch, producing plasma levels higher than those seen with Cilest (a combined oral contraceptive pill) but without the peaks and troughs of the oral regimen. Its main mode of action is the suppression of ovulation with secondary effects on cervical mucus and the endometrium.

It provides excellent contraception with a Pearl index of <1 per 100 woman years and it is promoted as having better adherence than the Pill as each patch lasts for seven days. It gives good cycle control and proved very acceptable to women in the clinical trials.³

**Side-effects** Side-effects include local skin reactions, breast tenderness (higher risk in the early cycles of use), headaches, breakthrough bleeding and nausea. The side-effect profile is similar to that of the combined pill.

**Management** The first patch is applied on day 1–5 of the cycle, with extra precautions for seven days if started after day 5.³ Additional contraception (condoms/avoidance of sex) is required for seven days if quick starting after progestogen-only emergency contraception (Levonelle 1500), and for 14 days following ulipristal acetate (Ellaone).⁴

Patches may be worn on the abdomen, thigh, buttock, deltoid area or upper torso. Each patch is worn for seven days and changed weekly over three consecutive weeks, followed by seven patch-free days during which a withdrawal bleed occurs.

The patches stay on well, but if one does become detached for less than 24 hours it can be reapplied or replaced immedi-

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**Table 1. Available types of non-oral contraception**

<table>
<thead>
<tr>
<th>Hormonal</th>
<th>Non-hormonal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injectables (Depo-Provera, Noristerat)</td>
<td>Male condoms</td>
</tr>
<tr>
<td>Subdermal implant (Nexplanon)</td>
<td>Female barriers</td>
</tr>
<tr>
<td>Transdermal patch (Evra)</td>
<td>Spermicides (usually used with a female barrier)</td>
</tr>
<tr>
<td>Intrauterine system (Mirena, Jaydess)</td>
<td>Copper intrauterine devices</td>
</tr>
<tr>
<td>Intravaginal ring (NuvaRing)</td>
<td></td>
</tr>
</tbody>
</table>
ataly without the need for extra precautions. If displaced for more than 24 hours, a new patch should be applied and condoms advised for seven days. Extending the patch-free interval by more than seven days risks pregnancy, as for COCs.

**Contraindications** These are similar to those for the combined pill, and include among many:
- pregnancy
- hormone-dependent tumours
- porphyria
- severe cirrhosis or liver tumour
- some cardiovascular diseases or risk factors
- focal migraine with aura.
The venous thromboembolism risk is similar to combined oral contraception and it is not currently recommended for use in anyone with a past history of thrombosis (UKMEC4).

**Summary** The Evra contraceptive patch is similar to the combined pill, with a similar side-effect profile. The same contraindications and cautions apply as for the COC but adherence may be better as the patch is changed weekly.

**NuvaRing**
NuvaRing is a once-a-month vaginal ring containing ethinylestradiol and etonogestrel. It delivers the lowest dose of oestrogen of any combined method and avoids the hepatic first-pass effect and interference with drug absorption.

**Management** The ring is inserted for three weeks continuously and then removed for one week during which a withdrawal bleed usually occurs. If the ring is removed or expelled there is no reduction in contraceptive efficacy if it is reinserted within three hours. If it is displaced for more than three hours during weeks 1 or 2, then it should be replaced and additional contraception advised for seven days. During week 3 a new ring may be inserted and retained for three weeks or a seven-day break taken and then a new ring inserted.

Contraceptive efficacy is adequate for four weeks. It may be started on day 1 of the cycle or on day 2–5 with additional precautions for seven days according to the licence. However, guidance from Faculty of Sexual and Reproductive Health (FSRH) care differs, with the advice that no extra precautions are required if started on day 1–5. Additional contraception (condoms/avoidance of sex) is required for seven days if quick starting after progestogen-only emergency contraception, and for 14 days following ulipristal acetate.

**Storage** Correct storage is essential. It must be delivered in a refrigerated system and once it has left the cold chain it must be inserted within four months. Once dispensed the user should store the rings at room temperature. This limits to four the number of rings that can be dispensed at any one time.

**Contraindications** and side-effect profile are the same as for Evra and the COC.

**Summary** NuvaRing gives excellent cycle control and is the only vaginal hormonal contraception available.

**Nexplanon**
Nexplanon is the latest generation of progestogen-only subdermal implant (see Figure 1) launched in October 2010. In clinical trials Nexplanon has demonstrated bioequivalence to the previous subdermal contraceptive implant Implanon, which is over 99 per cent effective.

The Nexplanon rod contains 68mg of etonogestrel and comes preloaded in an innovative disposable applicator, designed to be operated with one hand and facilitate insertion just below the skin. The implant itself is radio-opaque to make impalpable devices easier to locate on X-ray.

The implant is a single rod about the size and shape of a matchstick and is one of the LARCs. It is injected subdermally into the non-dominant arm, where it may be visible and should be palpable. It is a progestogen-only method, releasing 30–40µg etonogestrel daily over three years. Its primary mode of action is ovulation inhibition. Secondary effects include making the cervical mucus impenetrable to sperm and suppression of the endometrium.

Nexplanon is a very effective method of contraception with a failure rate of <1 in 1000 over three years. It is easy to insert and remove following adequate training. FSRH offers a competency-based training package.

**Side-effects** The main problems with Nexplanon are related to menstrual disturbance. Amenorrhoea will occur in 20 per cent of women, while 50 per cent will have some bleeding that may well be irregular and unpredictable. Bleeding is the most common reason women ask to have the implant removed. Other side-effects may include weight gain, weight loss, hair loss, acne and mood swings.

**Management** Nexplanon can be inserted on day 1–5 of the cycle, with extra precautions for seven days if started after day 5. Additional contraception (condoms/avoidance of sex) is required for seven days if quick starting after progestogen-only emergency contraception, and for 14 days following ulipristal acetate.

Before fitting (see Table 2), women must have adequate counselling and the opportunity to read the information leaflets and to ask questions. Many centres fit Nexplanon as a two-stage procedure and do not fit at the first visit in order to give women more time to consider the method. If irregular bleeding is a problem, Mefenamic Acid, the COC or oral

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**Figure 1. Nexplanon subdermal implant**

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**Injectable hormonal contraception**

There are three injectable contraceptives available in the UK, all progestogen-only methods.

**Noristerat**

Norethisterone enanthate 200mg is given by deep intramuscular injection every eight weeks. It suppresses ovulation with secondary effects on cervical mucus and the endometrium. It is not licensed for long-term use and is not widely used. The Pearl index is 0.5–1.5.

**Depo-Provera**

Medroxyprogesterone acetate (DMPA) 150mg is given by deep intramuscular injection every 12–14 weeks (see Figure 2). It works mainly by suppressing ovulation. There is a secondary effect on cervical mucus and the endometrium. Depo-Provera has a failure rate of <4 in 1000 over two years. Table 3 shows when to start Depo-Provera.

**Side-effects**

Menstrual disturbance is common. Irregular bleeding may occur after the first injection but amenorrhoea is common with longer use (70 per cent are amenorrhoeic at one year of use). The return to fertility may be delayed following even one injection. Weight gain, acne, mood swings and headaches are all reported after use.

**Bone density**

Several studies have investigated the effects of DMPA on bone mineral density (BMD). Most studies show that DMPA does reduce bone density but that this recovers after discontinuation. A 2004 study on DMPA use in 12–18 year olds showed a small decrease in BMD at both spine and hip, but no long-term follow-up was carried out.8,9

The very young (under 18) have not yet achieved peak bone mass; however, they tend to be short-term users and other factors, eg smoking, nutrition and lack of exercise, may be more important in influencing peak bone mass. NICE1 recommends that Depo-Provera may be used in very young women if other methods are unacceptable. The FSRH Clinical Effectiveness Unit recommends that DMPA may be used in women up to 50 years who have no other risk factors for osteoporosis and other methods are not acceptable. Again, an assessment of other risk factors should be a part of the discussion process.

**Management**

Depo-Provera is a LARC. Once given it cannot be rapidly reversed if there are side-effects such as amenorrhoea or irregular bleeding and there may be a long delay in return of fertility (the average is six months).10 Depo-Provera is not affected by enzyme-inducing medications and there is no reason to shorten the injection interval.

Lifestyle should be considered in any consultation about Depo-Provera, in particular the risks of smoking and the benefits of exercise and a good diet rich in calcium. Women requesting the progestogen-only injectable should ideally be offered a bridging method if pregnancy cannot be excluded, eg following admin-

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**Table 2.** Timing considerations and precautions when fitting Nexplanon

<table>
<thead>
<tr>
<th>Situation</th>
<th>Timing</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>No contraception</td>
<td>Day 1–5</td>
<td>Day 1–5, no extra precautions needed</td>
</tr>
<tr>
<td>Condoms/cap</td>
<td>Day 1–5</td>
<td></td>
</tr>
<tr>
<td>COC or POP</td>
<td>Any time if no Pill problems</td>
<td>None</td>
</tr>
<tr>
<td>Postpartum, can be used if breastfeeding, or post-2nd trimester termination</td>
<td>Day 21–28, may be fitted &lt;day 21 if needed</td>
<td>Condoms after day 28</td>
</tr>
<tr>
<td>Postmiscarriage or termination up to 24 weeks (&gt;24 weeks as postpartum)</td>
<td>Immediately</td>
<td>None</td>
</tr>
</tbody>
</table>

**Summary**

Nexplanon is a highly effective, safe method offering reliable contraception for three years. It is easy to fit and remove following training. It is suitable for almost everyone and its main side-effect is its unpredictable effect on bleeding patterns.
istration of emergency contraception, but immediate start is acceptable if other methods are not appropriate or acceptable.\textsuperscript{4}

\textbf{Late injections} If the patient attends up to 14 weeks since the last injection then it may be given without the need for additional contraception\textsuperscript{1} (off-licence use but is recommended by FSRH and NICE).

\textbf{Contraindications} The only condition considered to be UKMEC4 to the use of Depo-Provera is current breast cancer. Conditions where the risks outweigh the benefits include decompensated cirrhosis or liver tumour, current and past history of ischaemic heart disease or stroke, and peripheral vascular disease.

\textbf{Summary} Depo-Provera is a safe and highly effective long-acting contraceptive. It usually causes amenorrhoea. It has been shown to reduce bone density in long-term users and the risks and benefits for each individual woman should be considered prior to starting/continuing with Depo-Provera.

\textbf{Sayana Press} This is the most recent progestogen only injection to be launched in the UK. It comes in a single dose pre-filled injector. It contains 104mg of MPA in 0.65ml suspension and is given subcutaneously. The indications, contraindications and side-effect profile are very similar to Depo-Provera, Sayana Press may be preferable to IM DMPA in patients at risk of haematoma due to bleeding diseases or anticoagulation.\textsuperscript{11}

\textbf{Intrauterine contraceptive devices} There are a variety of devices licensed for 5–10 years of use and the 10-year devices are considered to be the gold standard. Most consist of a plastic T-shaped frame with copper round the stem, and some have copper on the arms.

Gynefix is a frameless device, consisting of a polypropylene thread with six copper tubes suspended from the fundus, designed to reduce pain and bleeding.

Copper devices are effective at preventing pregnancy with a failure rate of 1–2 per cent at five years.\textsuperscript{1,10} Efficacy is affected by the age of the woman (the older she is, the more effective the method), and the device chosen.

Copper is toxic to sperm and ova, and works primarily by inhibiting fertilisation.\textsuperscript{10} The IUDs cause a foreign-body reaction in the endometrium with increased production of prostaglandins and leucocyte infiltration. See Table 4 for a comparison of copper IUDs.

\textbf{Side-effects} \textit{Bleeding} All copper IUDs may cause an increase in duration and quantity of menstrual blood loss, with increased pain.

\textit{Infection} The risk of infection should be assessed for each individual woman by taking a sexual history.\textsuperscript{12} Women deemed at higher risk of sexually transmitted infection should be tested for chlamydia and gonorrhoea prior to insertion. A full screen should be offered if requested or indicated by the history.\textsuperscript{10} Ectopic pregnancy The overall risk of pregnancy is very small in IUD users. The annual ectopic rate for IUD use was 0.02 per 100-woman years compared with 0.3–0.5 per 100-woman years for women not using contraception.\textsuperscript{10}

Perforation The risk is around 1–2 per 1000 IUD insertion and increases six-fold in breastfeeding postpartum women. The woman may present with missing threads and/or abdominal pain and will require laparoscopy/laparotomy for removal.

\textbf{Management} Full counselling is essential before an IUD insertion. Prior to fitting, a sexual history should be taken and the woman

<table>
<thead>
<tr>
<th>Type</th>
<th>Duration of use (years)</th>
<th>Pearl index</th>
<th>Amount of copper (mm\textsuperscript{2})</th>
<th>Which woman?</th>
</tr>
</thead>
<tbody>
<tr>
<td>TT380 Slimline</td>
<td>10</td>
<td>0.1–0.3</td>
<td>380</td>
<td>Most</td>
</tr>
<tr>
<td>Multiload 375</td>
<td>5</td>
<td>0.3–0.5</td>
<td>375</td>
<td>Multiparous</td>
</tr>
<tr>
<td>Gynefix</td>
<td>5</td>
<td>0.3–1.0</td>
<td>330</td>
<td>Previous expulsion of copper IUD</td>
</tr>
<tr>
<td>Nova-T 380</td>
<td>5</td>
<td>0.5–2.0</td>
<td>380</td>
<td>Narrow cervical canal</td>
</tr>
<tr>
<td>Flexi-T 380</td>
<td>5</td>
<td>0.1–0.3</td>
<td>380</td>
<td>Useful as postcoital device</td>
</tr>
<tr>
<td>Mirena IUS</td>
<td>5</td>
<td>0.33–0.41</td>
<td>Levonorgestrel 52mg</td>
<td>All women but especially those with amenorrhagia/perimenopausal</td>
</tr>
<tr>
<td>Jaydess</td>
<td>3</td>
<td></td>
<td>Levonorgestrel 13.5mg</td>
<td>All women but especially those who prefer less amenorrhoea than with the Mirena</td>
</tr>
</tbody>
</table>

Table 4. Common IUD contraceptive devices, their properties and suitability for patients
screened for chlamydia and gonorrhoea if indicated. If detected, treatment of the woman and her partner(s) must be complete before proceeding. Screening and prophylactic antibiotics are offered by most centres at the time of emergency IUD insertion.

IUDs can be fitted up to five days after the expected date of ovulation or at any time if there is no risk of pregnancy. They can be fitted at the time of first or second trimester abortion. Postpartum they may be fitted up to 48 hours or after four weeks.

Postcoitally, they are fitted up to five days after unprotected intercourse or up to five days after the earliest expected date of ovulation. Follow-up is usually at three to six weeks and the woman should be encouraged to check regularly for her threads. Copper IUDs fitted after the age of 40 years may be left until the menopause is confirmed.

Unless a pregnancy is required, IUDs should be removed during the first five days of the cycle or the woman asked to abstain for seven days prior to removal. If removal is essential and intercourse has occurred, emergency hormonal contraception should be offered.

Contraindications

UKMEC4 contraindications include:
- undiagnosed vaginal bleeding prior to assessment
- pregnancy
- puerperal sepsis
- postseptic abortion
- endometrial cancer
- cervical cancer awaiting treatment
- current pelvic inflammatory disease
- trophoblastic disease
- Wilson’s disease or copper allergy
- marked distortion of the uterine cavity or anatomical abnormalities.

Intrauterine systems

Mirena contains 52mg of levonorgestrel and releases levonorgestrel 20µg per day into the endometrial cavity. The diameter of the insertion tube is 4.40mm. It acts locally by endometrial suppression and cervical mucus effects. Many believe it impedes fertilisation as well. It is also licensed for the treatment of heavy menstrual bleeding and as the progestogen component of HRT, making it particularly useful for contraception in the perimenopause as oestrogen can be added in for control of menopausal symptoms. It should be inserted during the first five days of the cycle or at any time if there is no risk of pregnancy. It must not be used for post-coital contraception as its effects on the endometrium are not immediate.

Jaydess was launched in 2014. It has a smaller frame than the Mirena, measuring 28 x 30mm, with the diameter of the insertion tube measuring 3.80mm (see Figure 3). It has a silver ring on the plastic T frame to differentiate it from other IUDs. It contains 13.5mg of levonorgestrel, releasing an average daily dose of 6µg. It is licensed for three years and for contraception only.

Levosert is a levonorgestrel intrauterine system (LNG-IUS) newly launched in the UK for contraception and management of heavy menstrual bleeding. It contains 52mg levonorgestrel (identical to Mirena) in a reservoir mounted on a T-shaped polyethylene frame. It is licensed for three years. It has an insertion tube diameter of 4.80mm and is inserted using a two-handed technique, with a similar introducer to copper IUDs such as the Nova-T and UT380.

Side-effects

Irregular bleeding is common following insertion of Mirena, but within 12 months bleeding is reduced or absent in 65 per cent of women. There is significantly less amenorrhoea with Jaydess than Mirena. This may be seen as a positive feature for those women who prefer to have a monthly bleed.

<table>
<thead>
<tr>
<th></th>
<th>Depo-Provera</th>
<th>Nexplanon</th>
<th>Mirena</th>
<th>Jaydess</th>
<th>Copper IUDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearl index</td>
<td>0.3</td>
<td>0.2</td>
<td>0.1–0.2</td>
<td>0.33–0.41</td>
<td>0.2–2.0</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Highly effective</td>
<td>Highly effective</td>
<td>Highly effective</td>
<td>Highly effective</td>
<td>Effective</td>
</tr>
<tr>
<td>Effective for</td>
<td>14 weeks</td>
<td>3 years</td>
<td>5 years</td>
<td>3 years</td>
<td>5–10 years</td>
</tr>
<tr>
<td>Amenorrhoea</td>
<td>Yes, 70% after 1 year</td>
<td>30%</td>
<td>30% amenorrhoea after 1 year</td>
<td>Lower rate of amenorrhoea than with Mirena</td>
<td>Periods regular but longer and heavier in some</td>
</tr>
<tr>
<td>Irregular bleeding</td>
<td>First 12 weeks</td>
<td>Common if first 6 months</td>
<td>For first 3–6 months, 65% have reduction in blood loss (persistent in a minority)</td>
<td>Usually for the first 3–6 months</td>
<td>None</td>
</tr>
<tr>
<td>Side-effects</td>
<td>Mood, weight gain, acne</td>
<td>Mood, weight gain, acne</td>
<td>Not usually after first</td>
<td>Not usually after the first 3 months</td>
<td>Long, heavy periods, dysmenorrhoea</td>
</tr>
</tbody>
</table>

Table 5. Comparison of the long-acting non-oral contraceptive options
Systemic side-effects such as breast tenderness, bloating and weight gain are usually transient and disappear within a few weeks of fitting. Other side-effects and fitting restrictions are similar to those of copper IUDs. Current breast cancer is a UKMEC4. Routine follow-up is not required for intrauterine contraception. A follow-up visit at two to six weeks is desirable, and the patient must be taught to feel for her threads and to return in the event of missing threads, concern about pregnancy, pelvic pain or dyspareunia or bleeding problems.

Summary
Copper IUDs and the IUS offer highly effective and convenient contraception for most women. There are few absolute contraindications.

Heavy but regular bleeding may be a problem with copper devices, and lighter but initially irregular bleeding a feature of the Mirena IUS.

Intrauterine devices should only be fitted by trained healthcare professionals. FSRH offers a competency-based training package for doctors and nurses.

Barrier methods
These are non-hormonal and therefore free from systemic side-effects, with no change in the menstrual cycle. They work by preventing the sperm meeting and fertilising the ovum.

Male condoms
These are readily available and widely used, and are manufactured in a range of sizes, shapes, flavours and colours. Efficacy varies, with a Pearl index of 2–15. As with any method of contraception, correct information is essential. A realistic model and written information are essential for teaching. Condoms can only be used once before disposal. Disadvantages of condoms include that they are intercourse related and may reduce spontaneity and sensitivity. They have variable efficacy.

Female condoms
Several types are available and all consist of a polyurethane tube with an inner ring that fits into the vagina, and an outer ring that sits on the vulva. The Pearl index ranges from 5–21.

Diaphragms
These are latex domes with a flexible spring, which sit across the vaginal vault. They come in a variety of sizes from 55–95mm. They have a Pearl index of 6–20. The woman should be assessed by a trained health professional and taught how to use her diaphragm. The diaphragm fits snugly between the symphysis pubis and the posterior fornix and covers the cervix and vaginal vault. The diaphragm may not be suitable for women with anterior or posterior prolapse. It should be reviewed if weight changes by more than 3kg and following pregnancy. A new single size contoured diaphragm is now available (Caya). The shape and size fits a broad range of women.

Figure 3. Jaydess intrauterine system

Barrier methods
There are two different sorts of cap, both of which fit over the cervix. They should be provided by experienced professionals.

Caps and diaphragms are used with spermicide before intercourse and should be left in place for six hours after intercourse.

Spermicides
Nonoxynol-9 is the only spermicide available in the UK, and is available as a gel. Recent evidence links it with a high risk of HIV transmission when used repeatedly; its use is still recommended, however, with caps and diaphragms but not with condoms.

Summary
Barrier methods are safe, free from side-effects, provide some protection against sexually transmitted infections and are readily available.

However, they can be messy and spontaneity may be affected. They are expensive to buy, can have a high failure rate and are damaged by oil-based lubricants.

Sterilisation
Male and female sterilisation is considered irreversible and involves a surgical procedure. Information about the full range of other LARCs should also be given when providing counselling and advice on sterilisation procedures. All verbal information must be supported by accurate impartial written information. Additional care must be taken when counselling people under the age of 30 years or people without children as a precaution against the risk of later regret.

Female sterilisation
This works by causing tubal occlusion, blocking the sperm and preventing fertilisation. It can be performed as a laparoscopic or hysteroscopic procedure.

Advantages It is highly effective and does not cause weight gain or heavy periods.

Disadvantages Laparoscopic sterilisation requires a general anaesthetic and reversal requires a major surgical procedure. Hysteroscopic sterilisation is carried out under local anaesthesia and cannot be reversed. There can be associated complications in 0.9–1.6 per 100 cases.

Male sterilisation (vasectomy)
In the UK, about 11 per cent of couples rely on male sterilisation as their chosen method. Male sterilisation techniques occlude the vas deferens using ligation or coagulation. This blocks the...
path of the sperm and prevents fertilisation. It can usually be done under local anaesthetic.

**Advantages** Safe and effective with a failure rate of about 1 in 2000.

**Disadvantages** Reversal is not very successful. It is not immediately effective and requires two negative semen analyses.

**Conclusion**

When a woman consults a health professional about contraception, all the available options should be discussed. If the non-oral route is chosen, then the next decision is long-acting versus short-acting (see Table 5 for a comparison of the long-acting options).

Eva or NuvaRing is a good choice for women who find it difficult to remember a daily pill.

All methods of contraception become more effective with increasing age, and barrier methods or spermicide alone are often chosen by perimenopausal women who no longer wish to take hormones.

If oestrogen is contraindicated, then the progestogen-only methods are highly effective. Depo-Provera takes a long time to wear off but Nexplanon is reversed upon removal.

The copper IUD provides highly effective contraception but may make periods worse. The intrauterine system is a good choice for women with heavy periods.

Sterilisation is highly effective but is irreversible and care should be taken in people under the age of 30 years. It also involves a surgical procedure.

The long-acting methods of contraception are highly cost-effective if retained for the full duration of their life-span. This is why detailed counselling is essential before embarking on a long-term method.

Whichever method is chosen the risks and benefits, and possible side-effects, must be discussed. Warning patients about side-effects and what to do if they occur improves user satisfaction and adherence and therefore reduces the risk of unintended pregnancy.

Every contraceptive consultation should be regarded as an opportunity to discuss lifestyle issues and to promote safer sex.

**References**

2. FSRH Clinical Effectiveness Unit. UK medical eligibility criteria for contraceptive use. 2009.
4. FSRH Clinical Effectiveness Unit. Quick starting contraception. September 2010.
7. FSRH Clinical Effectiveness Unit. Progestogen only implants. February 2014.

**Declaration of interests**

Dr Everett has received honoraria from several pharmaceutical companies. Dr Wokoma has received honoraria from BMS.

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