

SEXUAL & REPRODUCTIVE HEALTH · FOR GP TRAINEES & IMGs

Contraception in General Practice

Contraception is one of the commonest — and highest-value — things we do in primary care. This guide gives you the modern framework: how to **choose effectively**, how to **prescribe safely (UKMEC)**, what to do when **pills are missed**, and how to handle the **cases you will actually meet**. Page 2 lets you test yourself against worked answers.

1 Three questions that drive every consultation

① How effective must it be?

The less the user has to remember, the better it works. Steer toward **LARC** (the “fit and forget” tier) for the most reliable protection — see the ladder below.

② Is it safe for *this* person?

Check the method against the person's history using **UKMEC** (Section 3). UKMEC is about **safety, not effectiveness**.

③ What else does she want?

STI protection (only **condoms** do this), lighter periods (**LNG-IUD**), or no hormones (**copper coil**). Choice is shared and patient-centred.

2 The effectiveness ladder

MEMORY ANCHOR

Think of contraception in three tiers. **The fewer actions the user must take, the more effective the method**. Figures are approximate failures per 100 users in the first year (typical use).

TIER 1

Fit & forget

<1% / yr

LARC + sterilisation — most effective

Implant (<1 in 1000) · IUD · LNG-IUD (IUS) · Injection · Vasectomy · Female sterilisation

No daily action needed → typical use ≈ perfect use.

TIER 2

Remember regularly

~9% / yr

Combined pill · Patch · Ring · POP

Effective when used perfectly, but real-life “typical use” lets pregnancies through.

TIER 3

Remember every time

~18% / yr

Condoms · Diaphragm / cap

Least reliable alone — but condoms are the **only** method that also protects against STIs.

More reliable ↑ · needs more user effort ↓

TEACHING POINT

Quote **typical-use** figures when counselling — they reflect real life. The single biggest gain in reliability comes from removing the need to remember: that is the case for offering **LARC first** to everyone.

Effectiveness figures: FSRH / contraceptive-effectiveness data (Trussell; CDC US-SPR). “LARC” = long-acting reversible contraception.

What's inside

3 · UKMEC — the safety check & how to work it out

4 · Every method at a glance

5 · Missed pills — rules by pill type

6 · Emergency contraception

7 · Make every contact count

8 · Six cases — test yourself (page 5–6)

3 UKMEC — the safety check (and how to work it out)

NOW ESSENTIAL

UKMEC = UK Medical Eligibility Criteria. For any medical condition or characteristic, it tells you **how safe a method is** — it does *not* tell you how effective it is. Published by the **College of Sexual & Reproductive Health (CoSRH)** — renamed from the FSRH in August 2025. The current edition is **UKMEC 2025**, which replaced UKMEC 2016.

The four categories — read them like traffic lights

- 1 No restriction**
Use the method freely — green light.
- 2 Benefits generally outweigh risks**
Usually use it — proceed with light caution.
- 3 Risks usually outweigh benefits**
Generally avoid; needs expert judgement / specialist. Use only if better options unsuitable.
- 4 Unacceptable health risk**
Do **NOT** use the method — red light, stop.

How to work out a person's category

- List the person's conditions and characteristics (age, BMI, BP, smoking, migraine, VTE history, etc.).
- Look each one up for the method you're considering.
- **The method's category = the single highest (worst) number that applies.** You do not add scores together.
- But **multiple risk factors** for clot or arterial disease raise overall risk — use clinical judgement. Several "2"s may mean cumulative risk; several "3"s may be unacceptable.
- **Initiation** (starting) and **continuation** can carry different categories.

WORKED EXAMPLE

A 36-year-old who smokes 20/day and gets migraine with aura asks for the combined pill.

- Migraine with aura → CHC **4**
- Smoking ≥15/day at age ≥35 → CHC **4**

Verdict: combined pill is contraindicated. Offer a progestogen-only or non-hormonal method — for her, most are UKMEC 1–2.

Combined hormonal contraception (CHC): the conditions that matter most

CHC contains oestrogen, so clot and arterial risks dominate. **You must screen for these before prescribing.**

UKMEC 4 — do NOT use CHC	UKMEC 3 — generally avoid CHC
Migraine with aura (any age)	Smoking <15/day at age ≥35 (or stopped <1 yr ago)
Smoking ≥15/day and aged ≥35	BMI ≥35 kg/m ²
Current breast cancer	Adequately controlled / BP 140–159 over 90–99
Current or past VTE; known thrombogenic mutation	Migraine <i>without</i> aura starting at age ≥35; past migraine with aura
BP ≥160/100 mmHg	Immobility (e.g. wheelchair use)
Vascular disease, ischaemic heart disease or stroke	Known hyperlipidaemia; current gallbladder disease
<6 weeks postpartum and breastfeeding	6 weeks–6 months postpartum & breastfeeding
Major surgery with prolonged immobility	On enzyme-inducing drugs
SLE with positive antiphospholipid antibodies	
Severe cirrhosis / liver tumour; complicated valvular disease; diabetes with severe vascular complications	

NEW IN UKMEC 2025

Added: **multiple sclerosis, chronic kidney disease, sickle cell trait** and clarified e-cigarette use. Several **DMPA** categories were raised where there is extra clot risk. "Depression" was replaced by an overarching **mood-disorder** statement (counsel and monitor mood).

Source: CoSRH UK Medical Eligibility Criteria (UKMEC 2025) and Summary of Key Changes, December 2025. List is selected, not exhaustive — always check the full UKMEC for the individual.

THE SAFE FALLBACK

When oestrogen is a problem, remember that **progestogen-only and non-hormonal methods are UKMEC 1–2 for almost everyone** — including smokers over 35, those with migraine with aura, high BMI, controlled hypertension and breastfeeding mothers. The notable exception is **current breast cancer** (UKMEC 4 for all hormonal methods). When in doubt about CHC, a progestogen-only method or a copper coil is usually the safe, effective answer.

4 The methods at a glance

For each method, know the **mode of action, effectiveness, key cautions, common problems, the warnings you must give, and how long it lasts.**

Combined hormonal contraception

≈ 9 in 100 typical

FORMS	Pill, patch, vaginal ring (all oestrogen + progestogen).
ACTION	Mainly stops ovulation ; also thickens mucus, thins endometrium.
CAUTIONS	Oestrogen → clot/arterial risk. Screen with UKMEC (Section 3).
PROBLEMS	Early irregular bleeding, breast tenderness; small rise in VTE, breast & cervical cancer risk (falls after stopping).
WARN	You must give the clot warning: calf pain/swelling, breathlessness or chest pain → seek urgent help. New migraine with aura → stop CHC. Know the missed-pill rule.
LASTS	Until age 50 if no contraindication. Tailored / continuous use is supported — a monthly break is not required.

Progestogen-only pill (POP)

≈ 9 in 100 typical

TYPES	Desogestrel (12-h window), traditional LNG/NET (3-h window), drospirenone (24-h window).
ACTION	Desogestrel & drospirenone mainly stop ovulation ; traditional mainly thicken mucus.
CAUTIONS	Very few. Current breast cancer = UKMEC 4. Useful when CHC can't be used (aura, smokers ≥35, breastfeeding).
PROBLEMS	Unpredictable bleeding — the commonest reason for stopping. Counsel up front.
NOTE	Desogestrel POP is now available over the counter from pharmacies.
LASTS	Can be used to age 55.

Implant (etonogestrel)

< 1 in 1000 — most effective

ACTION	Single subdermal rod; stops ovulation. "Fit and forget".
CAUTIONS	Few. Current breast cancer = UKMEC 4.
PROBLEMS	Unpredictable bleeding — the main reason for early removal; counsel before fitting.
LASTS	3 years. Rapid return to fertility on removal.
WHY OFFER	The most effective reversible method available — promote it.

Injectable (DMPA)

> 99% perfect use

FORMS	Intramuscular (Depo-Provera) or subcutaneous (Sayana Press, can self-inject).
ACTION	Stops ovulation. Give every 13 weeks (up to 14 weeks is fine).
PROBLEMS	Irregular bleeding → often no periods; weight gain; delayed return of fertility (up to ~1 year) ; small, reversible loss of bone density.
CAUTIONS	Weigh bone effect in under-18s and over-45s; review by ~50. Some 2025 categories raised for clot/bone risk.

Intrauterine contraception (the "coil")

> 99% — < 1 in 100

Copper IUD (Cu-IUD) — non-hormonal

- Copper is toxic to sperm — **prevents fertilisation.**
- Works **immediately**; lasts **5–10 years.**
- Also the **most effective emergency contraception.**
- Periods often **heavier, longer, more painful.**

LNG-IUD (the hormonal "IUS", e.g. Mirena)

- Thickens mucus, thins endometrium → **lighter periods.**
- Treats heavy menstrual bleeding; used for HRT endometrial protection.
- Lasts **5–8 years** (device-dependent).
- FSRH now calls the IUS the "LNG-IUD".

SAFETY-NETTING — YOU MUST TEACH THIS

Teach her to **feel for the threads** after each period. Return if she **cannot feel the threads**, has **severe pelvic pain, fever, abnormal discharge or bleeding**, or thinks she may be **pregnant**. Small risks: expulsion, perforation (~1–2 per 1000 fittings), infection in the first 20 days; if it fails, a higher proportion are ectopic.

Barrier methods

condoms ≈ 18 in 100 typical

CONDOMS	External or internal. The only method that also protects against STIs. Always promote alongside another method ("Double Dutch").
DIAPHRAGM / CAP	Used with spermicide; user-dependent (~12 in 100 typical); less commonly chosen today.

QUICK STARTING — DON'T SEND HER AWAY TO WAIT

If you are **reasonably sure she is not pregnant**, you can **start most methods straight away ("quick start")** on any day of the cycle rather than waiting for the next period — this prevents missed opportunities. Advise **extra precautions** for the first **7 days** (combined pill, patch, ring, implant, injection, LNG-IUD) or **2 days** (progestogen-only pill), and arrange a **pregnancy test in ~3 weeks** if there was a recent risk. After **ulipristal** emergency contraception, wait **5 days** before starting a hormonal method.

5 Missed pills — the advice differs by pill

HIGH-YIELD

Combined pill (COC)

A pill is “missed” when **>24 hours late** (≥48 h since the last pill). The danger is a **long gap with no hormones** — never lengthen the pill-free week.

How many active pills missed?

(take the most recent missed pill now — even 2 in a day)

1 pill missed

Take it now, carry on.
No extra protection.
No emergency contraception needed.



2 or more missed

Use condoms / abstain until 7 pills in a row.
Wk 1 + sex in break/wk1 → EC
Wk 2 → no EC if wk1 correct
Wk 3 → skip the break, start next pack at once
+ consider EC if unsure

Progestogen-only pill (POP)

The “late” window depends on the type. Past that window the pill counts as **missed**.

POP type	“Missed” if later than
Traditional (levonorgestrel / norethisterone)	3 hours
Desogestrel	12 hours
Drospirenone	24 hours

IF A POP IS MISSED

Take one pill **as soon as you remember**, carry on as normal, and **use condoms or abstain for 48 hours. Consider emergency contraception** if unprotected sex happened during the unprotected window.

SAME LOGIC FOR OTHER METHODS

A **combined patch/ring** off for >48 h, or a **DMPA injection >14 weeks** late, follows the same idea: cover the gap and consider EC if there was a risk.

6 Emergency contraception (EC)

Three options. **The copper coil is the most effective and should be offered first.** Oral EC works mainly by **delaying ovulation**, so it fails once ovulation has happened.

Method	Time window	Key points
Copper IUD most effective	Up to 5 days after sex, or up to 5 days after the earliest expected ovulation	>99% effective. Offer to everyone. Not affected by weight or enzyme inducers. Bonus: gives ongoing contraception. Offer first.
Ulipristal acetate 30 mg (ellaOne)	Up to 120 hours (5 days)	More effective than levonorgestrel, especially mid-cycle. Do not use if a progestogen was taken in the last 7 days. Delay starting hormonal contraception for 5 days afterwards. Caution in severe asthma on steroids.
Levonorgestrel 1.5 mg	Up to 72 hours	Double the dose to 3 mg if BMI >26 or weight >70 kg , or on enzyme inducers. Hormonal contraception can be started immediately afterwards.

ALWAYS DO THESE THREE THINGS

1. Arrange **ongoing contraception** (quick-start where appropriate). 2. Offer an **STI screen**. 3. Advise a **pregnancy test if the next period is late, lighter or unusual**. After ulipristal, that test confirms it worked before restarting hormones.

Sources: FSRH guidelines — Combined Hormonal Contraception; Progestogen-only Pills; Recommended Actions after Incorrect Use of CHC; Emergency Contraception (amended 2026). NICE CKS Contraception.

DON'T FORGET DRUG INTERACTIONS

Enzyme-inducing drugs (e.g. some anti-epileptics, rifampicin/rifabutin, certain HIV drugs and **St John's Wort**) speed up hormone breakdown and **reduce the effectiveness of the pill, patch, ring, POP and implant**. They do **not** affect the **copper coil, LNG-IUD or injection** — so for someone on long-term enzyme inducers, a **coil or injection is the reliable choice**. Always check the BNF for the specific interaction.

7 Make every contact count

A contraception consultation is a golden opportunity for wider preventive care.

Screening & sexual health

- Cervical screening up to date?
- STI screen & safer-sex advice
- Rubella / HPV immunity

Lifestyle & risk

- Smoking cessation
- Alcohol; weight / BMI
- Blood pressure check

Looking ahead

- Pre-conception **follic acid 400 mcg** daily (5 mg if higher risk)
- Review any teratogenic drugs
- Mental health & mood

ALWAYS HAVE SAFEGUARDING ON YOUR RADAR

Ask sensitively about **coercion and domestic abuse**, and — for young or vulnerable people — about **exploitation**. This is part of safe contraceptive care, not an optional extra.

8 Test yourself — six cases, brief model answers

APPLY IT

Cover the answer, think it through, then check. These mirror the patients you will actually see.

1 A 15-year-old girl asks you for the pill.

MODEL ANSWER

Assess **Fraser / Gillick competence**: does she understand the advice, is she likely to have sex with or without contraception, would her health suffer without it, can she be encouraged to involve a parent, and is treatment in her best interests? Care is **confidential** — but **you must consider safeguarding**: the age and identity of her partner, any coercion or exploitation, and her capacity. Offer the **full range, including LARC** (age is not a barrier). Promote **condoms** for STI protection, give health-promotion advice, and **document the Fraser assessment**.

2 A 23-year-old mother of two no longer wants the pill and asks for advice.

MODEL ANSWER

Explore **why** she wants to stop (side effects? remembering it?). Discuss the **full range**, and actively offer **LARC** — “fit and forget” and the most effective option. Run a quick **UKMEC** check for anything she chooses. The decision is hers; your job is clear, balanced information and a method that fits her life.

3 A postnatal, breastfeeding mother asks to go back on “the pill”.

MODEL ANSWER

The right “pill” here is the **progestogen-only pill** — safe in breastfeeding, no effect on milk, and started any time (no extra cover if it's within 21 days of birth). **You must NOT start the combined pill before 6 weeks if she is breastfeeding** (UKMEC 4 under 6 weeks; UKMEC 2 thereafter). Also offer **LARC** (implant or coil are both safe). Explain that lactational amenorrhoea is only reliable while fully breastfeeding, amenorrhoeic and under 6 months postpartum.

4 A 17-year-old had unprotected sex on Friday night and sees you Monday evening, worried about pregnancy and HIV.

MODEL ANSWER

Pregnancy: it is about 72 hours, so act now. Offer the **copper coil first** (most effective, up to 5 days). If declined, **ulipristal acetate** works up to 120 hours, or **levonorgestrel** up to 72 hours. **HIV (not “AIDS”)**: assess the risk — **PEP must start within 72 hours**, so if there is meaningful risk **refer urgently to sexual health or A&E tonight** to discuss it before the window closes. Offer an **STI screen** (chlamydia, gonorrhoea, HIV, syphilis — mind the window periods), arrange **ongoing contraception**, keep care **confidential**, and still **consider safeguarding** at 17.

5 A 28-year-old had a coil fitted 3 months ago and has had two prolonged, heavy periods.

MODEL ANSWER

Exclude danger first. Do a **pregnancy test**. Assess for **infection / PID** (pain, discharge, fever) and screen for STIs if at risk. **Examine and check the threads** to exclude expulsion, malposition or perforation — arrange an **ultrasound if the threads cannot be seen**. Then **reassure**: a **copper coil** commonly causes heavier, longer periods, especially in the first 3–6 months, and this often settles. Options to reduce bleeding include **tranexamic acid** and/or an **NSAID such as mefenamic acid**. If bleeding stays unacceptable and she still wants long-acting contraception, offer to **switch to the LNG-IUD**, which makes periods lighter.

6 A 27-year-old couple with two children ask about **sterilisation**.

MODEL ANSWER

Counsel **both options**. **Vasectomy is simpler, safer and more effective** — lifetime failure about **1 in 2000**, versus about **1 in 200** for female sterilisation. Stress that sterilisation is **permanent**: they must be certain, and reversal is not routinely available. Because they are young, **discuss LARC** (implant or coil) — just as effective and fully reversible. After **vasectomy**, contraception must continue until a **semen test at ~12 weeks confirms no sperm**. After **female sterilisation** protection is immediate, but advise contraception until the next period. Refer via the local pathway.

One-line memory hooks

Less to remember = more effective → offer LARC first

UKMEC = safety, not effectiveness

Category 4 = red light = do NOT use

1 missed COC = relax · 2+ = condoms 7 days

Never lengthen the pill-free week

Copper coil = best emergency contraception

Oral EC delays ovulation — useless once you've ovulated

Breastfeeding + "pill" = POP, not COC before 6 weeks

"AIDS" → say HIV · PEP within 72 h

Vasectomy beats tubal for safety & failure rate

Primary sources (verify before applying in practice). CoSRH/FSRH: UK Medical Eligibility Criteria **UKMEC 2025** & Summary of Key Changes (Dec 2025); FSRH Clinical Guidelines — Combined Hormonal Contraception (2019, amended 2023), Progestogen-only Pills (2022, amended 2026), Progestogen-only Injectable, Progestogen-only Implant, Intrauterine Contraception (2023, amended 2025), Emergency Contraception (2017, amended 2026), Contraception After Pregnancy (2020). **NICE** CKS Contraception (assessment; combined; progestogen-only methods) & NICE PH51 Contraceptive services for under-25s (Fraser). **RCOG/FSRH** Male & Female Sterilisation. **BASHH** UK Guideline for the use of HIV Post-Exposure Prophylaxis (2021). **NICE** pre-conception folic acid guidance.

Note on changes from the original 2004 tutorial: terminology updated ("AIDS" → HIV); UKMEC framework, the implant, missed-pill rules, modern emergency-contraception options and quick-starting added; the outdated "item-of-service fee" question removed (contraception is now delivered under the GMS contract, with LARC fitting commonly funded via local enhanced services). A full change log is provided in the accompanying summary.