A personalised choice after receiving detailed and clear information

- The contraceptive method must be suited to each woman and chosen by and with her, in accordance with her daily life and any contraindications. The method chosen may change over the woman’s life and in accordance with situations encountered by the woman and/or the couple.

- The partner’s involvement in choosing the contraception can have a positive impact on compliance with and acceptance of the method.

2. In these conditions, a simple and practical decisional algorithm is not conceivable.

A dedicated consultation

- A woman asking for contraceptive advice for the first time should be offered a consultation dedicated to this purpose only, regardless of her age. If it is not possible (in an emergency, for example), schedule a fully dedicated consultation in the short-term.
An essential consultation in the process of helping with the choice

→ It is a consultation for listening, exchange and dialogue that should respect intimacy and confidentiality.
→ The consultation should provide the opportunity to:
  • assess the woman’s expectations and needs, her knowledge and her lifestyle habits;
  • provide tailored, clear and tiered information on the contraceptive methods that are available (including sterilisation) and suitable for the person requesting information, and ensure that the person has understood this information;
  • advise on and/or prescribe the method chosen by the woman, the most suitable and acceptable for her according to her preferences, her state of health, the benefit-risk ratio of the various methods, and how possible it is for her to adhere to the method depending on her circumstances and lifestyle habits.


An interview with a broad scope on a medical level as well as in terms of the woman’s experience

→ The collection of information covers a wide area:
  • age, profession, lifestyle habits (smoking, sex life [risk of infection]), contraceptive methods used to date, date of last period, breastfeeding underway;
  • number of children, previous miscarriages and terminations;
  • family history in first-degree relatives (parents, brothers and sisters or children) of venous or arterial thromboembolic events (age at which they occurred and, if possible, circumstances in which they occurred), arterial hypertension (AHT), diabetes, dyslipidaemia;
  • personal history:
    • venous or arterial thromboembolic events, AHT, diabetes, dyslipidaemia, migraine with or without aura,
    • other medical (cardiovascular and neurological), surgical or obstetric and gynaecological (particularly sexually transmitted infections [STIs], ectopic pregnancies, cancers, and uterine, trophoblastic or vaginal disease or surgery) history;
  • treatments in progress (anticipating possible drug interactions).

A physical examination and laboratory tests to look for any contraindications but also for prevention

→ The physical examination comprises: general examination, weight, height, body mass index (BMI), blood pressure (BP).
→ The gynaecological examination can be explained and scheduled for a future consultation, especially in the case of adolescents.
→ The breast examination and the gynaecological examination (with cervical smear from the age of 25) aims to screen for cancer and precancerous lesions.
A physical examination and laboratory tests to look for any contraindications but also for prevention (cont., last page)

- When an oestrogen-progestogen hormonal contraceptive (pill, patch, ring) is prescribed, the laboratory work-up:
  - comprises determination of total cholesterol, triglycerides and fasting blood sugar:
  - should be renewed every 5 years if the results are normal and if there are no new clinical or family information,
  - in a person with no personal or family history of metabolic or thromboembolic disease, who does not smoke and whose physical examination is normal, can be carried out 3 to 6 months after the contraception is prescribed,
  - if there is family history of dyslipidaemia, should be carried out before starting any oestrogen-progestogen contraceptives and 3 to 6 months afterwards;
  - may include a test for haemostasis (determinations of antithrombin, protein C, protein S, resistance to activated protein C or testing for the Factor V Leiden mutation and the mutation of prothrombin or Factor II G20210A): to be discussed after specialist advice if there is personal or family history of thromboembolic disease (which occurred in a first-degree relative before the age of 50-60 years).

- Before inserting an intrauterine device, if there is a risk of infection (particularly some STIs, current or recent pelvic inflammatory disease, age < 25 years, multiple partners), test for a *Chlamydia trachomatis* infection and a *Neisseria gonorrhoeae* infection.

Information to be given to the woman on existing methods and ways of using the chosen method

Provide information on

- Contraceptive methods:
  - mechanism of action and directions for use: when to start the chosen contraception; how to take the chosen pill and, together with the woman, find the most suitable time; what to do if she forgets; how to use the patch or vaginal ring; how and when to insert an intrauterine device or an implant; how to use the various barrier methods,
  - efficacy (optimal and in current use 4), contraindications, advantages, risks and possible side effects, procedure for starting or discontinuing (or removing), cost, reimbursement and the after-insurance cost, etc.;

- The opportunities for receiving help with giving up smoking if she is a smoker;

- The opportunities for contacting a professional (doctor, pharmacist, midwife, nurse, marriage or family counsellor) if in doubt about how to use the contraception:

- The various “rescue options” if she has unprotected sex (emergency contraception), their efficacy and the conditions of access;

- The symptoms, in simple terms, which might suggest a complication (depending on the method chosen) and about which the woman must consult a doctor or a midwife;

- The need for the woman to inform any doctor that she is taking hormonal contraception in case of intercurrent treatment (risk of drug interaction), a surgical procedure, prolonged immobilisation and long flights;

- The need for her to anticipate when she is going to need repeat prescriptions so that she does not interrupt her contraceptive treatment;

- STIs/AIDS, prevention using condoms (male and female).

4. Efficacy is usually described using the Pearl index, which corresponds to the ratio of the number of pregnancies to the total number of cycles observed for all the women studied, and reported in 1 year. The result is expressed in pregnancies per 100 women per year. The efficacy data concerning a contraceptive method distinguish the optimal efficacy corresponding to that obtained in the therapeutic trials from the efficacy in current use.
A follow-up to assess the suitability of the method chosen, compliance, safety and satisfaction of the woman

- Assess the suitability of the contraceptive method and the woman’s satisfaction: if the woman is dissatisfied or has intolerance, remind the woman of other contraceptive methods and suggest that she considers them.
- Take into account the changes in the woman’s personal, medical, emotional and social situation that could alter the suitability of the method.
- Assess compliance: frequency and circumstances of her forgetting; together with the woman, find the most suitable time to avoid her forgetting; reassess her knowledge and reiterate the advice on what to do if she forgets and tell her about emergency contraception (to be used as quickly as possible after unprotected sex).
- Each time the prescription is repeated, reassess the risks depending on the method chosen.
- Repeat information on the opportunities for giving up smoking if the woman is a smoker.
- In women using 3rd generation oestrogen-progestogen contraceptives containing desogestrel or gestodene, and 4th generation combined contraceptives containing drospirenone, the increased risk of venous thromboembolism does not justify abruptly discontinuing this contraception that had been well tolerated up to that point. At the end of the current prescription, the prescriber will plan with the woman another more suitable contraceptive method for her (another hormonal contraceptive, intrauterine device, etc.).
- The literature reports a possible increased risk of venous and arterial thromboembolism depending on the doses of ethinylestradiol contained in the oestrogen-progestogen contraceptives.
- The medical follow-up includes:
  - questioning on the health problems which have occurred since the last consultation and on taking the medicinal products;
  - a physical examination: weight, height, BMI, BP, breast and gynaecological examination if necessary;
  - a cervical smear: two smears with an interval of 1 year then every 2 years from the age of 25 years (if normal smear);
  - laboratory tests: total cholesterol, triglycerides and fasting blood sugar every 5 years if oestrogen-progestogen contraceptive (pill, ring or patch).
- Remind the woman of the guidelines for protection against sexually transmitted infections and AIDS (benefit of condoms, option of HIV screening, particularly during a monitoring blood test).
- Schedule the next consultation: first consultation at 3 months then generally one consultation a year if the woman is well, more often and as many times as necessary if difficulties are encountered with the contraception or there are symptoms suggesting a complication.

5. See card “What to do if you miss a pill”.

Learn more

Web sources

- Association fil-santé jeunes [Young People’s Healthline]: www.filsantejeunes.com
- Association française pour la contraception [French Association for Contraception]: www.contraceptions.org
- Choisir sa contraception [Choose your contraception]: www.choisirsacontraception.fr
- Haute Autorité de Santé: www.has-sante.fr
- National Prevention and Health Education Institute: www.inpes.sante.fr