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Review Article

Acceptability and women's perceptions on progesterone only contraception: a comprehensive review

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ABSTRACT

Progesterone-only contraceptives (POCs) represent a crucial pillar of modern family planning, offering highly effective options free from oestrogen-related cardiovascular risks. This review systematically examines patient preferences, satisfaction rates, and acceptability profiles across the primary POC modalities: progesterone-only pills (POPs), subdermal implants, long-acting injectables, and levonorgestrel-releasing intrauterine systems (LNG-IUS). Based on multi-country trial networks, health technology assessments, and real-world database registry cohorts, this paper details how bleeding abnormalities, return-to-fertility expectations, and metabolic profiles drive patient adherence or premature discontinuation. While long-acting reversible contraceptives (LARCs) exhibit the highest objective continuation rates, individual consumer choices are profoundly shaped by non-contraceptive benefits, user autonomy, and cultural perspectives. Strategic, structured patient counselling that balances expected bleeding disruptions against highly effective, discrete therapeutic benefits remains the definitive clinical intervention to improve long-term user satisfaction and minimize unmet contraceptive needs.

Keywords: Progesterone-only contraceptives, Patient acceptability and satisfaction, Long-acting reversible contraception, Contraceptive counselling, Bleeding irregularities

INTRODUCTION

The landscape of contraceptive care has undergone a substantial transformation over the past few decades, shifting from a predominantly efficacy-focused paradigm to towards one that emphasizes patient autonomy, reproductive justice, and person-centred decision-making.[1,2] While prevention of unintended pregnancy remains the principal objective of contraception, contemporary family planning services increasingly recognize that contraceptive success cannot be adequately measured by efficacy alone.[3] Rather, successful contraceptive use is determined by a complex interaction between method effectiveness, user satisfaction, acceptability, continuation, and alignment with an individual's reproductive goals and preferences.[3,4] Consequently, patient-centred outcomes have emerged as critical endpoints in contraceptive research and clinical practice.[2,4]

Modern family planning services increasingly rely on progesterone-only contraceptives (POCs) to serve diverse reproductive populations. Erhardt-Ohren et al found that globally, approximately 8% of sexually active, fertile women wishing to delay or space pregnancies still face an unmet need for modern family planning.[5] While combined hormonal contraceptives (CHCs) containing oestrogen remain highly popular, they carry definitive contraindications for specific patient populations.[6] Conditions such as postpartum lactation, severe hypertension, a history of deep vein thrombosis (DVT), migraines with aura, or an elevated risk of cardiovascular events steer clinical decision-making toward POC alternatives.[6]

Progesterone only contraception (POCs) modalities span a diverse pharmacological spectrum:

Short-acting oral formulations include traditional and novel progesterone-only pills (POPs).[7]

Injectable systems include depot medroxyprogesterone acetate (DMPA).[8]

Long-acting reversible contraceptives (LARCs) include subdermal etonogestrel (ENG) implants and levonorgestrel-releasing intrauterine systems (LNG-IUS).[9]

A classic challenge across all progesterone-only delivery systems is the alteration of endometrial architecture, which frequently leads to unpredictable, unscheduled bleeding or spotting.[6,10] For some individuals, this results in early discontinuation, while for others, secondary amenorrhea becomes a desired non-contraceptive asset.[6]

Despite their objective efficacy, the clinical success of any contraceptive method depends entirely on patient compliance, method continuation, and personal acceptability.[4] Acceptability is not merely a reflection of a device's failure rate; it is a complex behavioural composite shaped by side-effect profiles, perceived ease of use, socio-cultural expectations, and systemic barriers to access.[11] Acceptability is a multidimensional construct encompassing willingness to initiate a method, satisfaction during use, tolerance of adverse effects, continuation over time, and willingness to recommend or reuse the method.[3,11] Unlike efficacy, which is primarily determined by biological and pharmacological factors, acceptability is influenced by a wide range of psychological, social, cultural, and healthcare-related determinants.[4,11] Consequently, two individuals using the same contraceptive method may report markedly different experiences despite similar clinical outcomes.

The importance of patient preference is further highlighted by evidence demonstrating that continuation rates differ substantially among progesterone-only methods despite uniformly high contraceptive effectiveness.[9,12] Recent developments in reproductive healthcare have also emphasized the principles of shared decision-making and reproductive autonomy.[1,2] Rather than directing patients toward a particular method, clinicians are increasingly encouraged to facilitate informed choices that reflect individual preferences and circumstances.[2]

This comprehensive review evaluates current literature on the distinct acceptability landscapes of POPs, implants, injectables, and intrauterine devices. By analysing patient preferences and the physiological variables driving them, this article provides clinicians with an evidence-based framework to guide patient counselling and optimize long-term contraceptive satisfaction.

PHARMACOLOGICAL MECHANISMS AND CONTRACEPTIVE DELIVERY SYSTEMS

Progesterone prevent pregnancy through three distinct, mutually reinforcing physiological mechanisms, depending on their systemic concentration.

Suppression of the hypothalamic-pituitary-ovarian (HPO) axis

By decreasing the pulsatile secretion of gonadotropin-releasing hormone (GnRH), progesterone blunts the mid-cycle luteinizing hormone (LH) and follicle-stimulating hormone (FSH) surges, reliably suppressing ovulation.[13]

Thickening of the cervical mucus

Progesterone maintain cervical secretions in a dense, low-volume, oestrogen-depleted state, rendering the mucus highly impermeable to sperm penetration.[13]

Endometrial alterations

Continuous exposure to progesterone prompts glandular atrophy and stromal decidualization, creating an unfavourable environment for embryonic implantation, complemented by reduced ciliary tubal motility.[13,14]

Table 1: Delivery systems for the mechanisms.

Delivery system	Active compound	Systemic pharmacokinetics	Primary advantage
Oral POPs	Norethisterone, Desogestrel, or Drospirenone	Rapid daily peaks followed by clearing cycles; requires consistent daily dosing schedules.[7]	Complete user autonomy; instant non-surgical reversibility.[7]
Injectable DMPA	Medroxyprogesterone acetate	High-dose deep muscular/subcutaneous depot; systemic peaks slowly taper over 11–13 weeks.[8]	Discrete administration; high rates of secondary amenorrhea.[8]
Subdermal implants	Etonogestrel (ENG)	Controlled zero-order continuous release via ethylene vinyl acetate membrane over 3 years.[15]	highest mechanical efficacy; eliminates daily compliance.[9]
LNG-IUDs	Levonorgestrel	High local endometrial concentrations with low, stable systemic blood levels over 3–8 years.[16]	Profoundly reduces menstrual blood loss; minimal systemic side effects.[16]

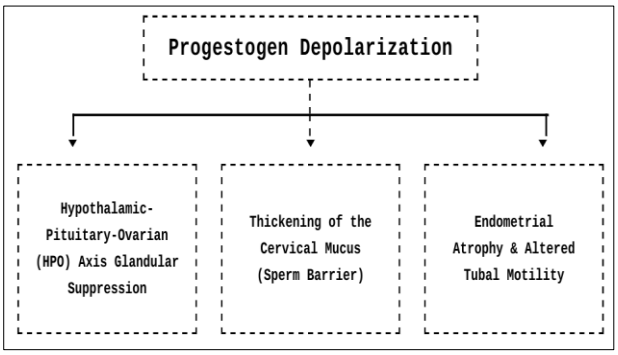

Figure 1: Progesterone depolarization.

Understanding these distinct drug dynamics helps explain why different progesterone-only methods produce unique side effects and varying levels of patient satisfaction.

THE PROGESTERONE-ONLY PILL: PATIENT AUTONOMY VERSUS DOSING DISCIPLINE

Oral contraception remains a popular option for patients who value complete control over their daily routine and wish to avoid minor in-office clinical procedures. However, patient preferences regarding POPs have historically been limited by strict dosing requirements.[6,7]

Traditional first-generation POPs

Traditional first-generation POPs, such as those containing low-dose norethisterone, operate with a narrow therapeutic window.[6] These formulations rely heavily on thickening cervical mucus rather than consistently suppressing ovulation.[13] Because plasma levels decline rapidly, the effective drug window lasts only about 22 hours, leaving a strict 3-hour delay margin for missed pills.[6]

Clinical registry data indicates that this unforgiving schedule leads to significant user anxiety and higher typical-use failure rates (around 7%), which negatively impacts overall satisfaction and preference metrics.[6,12]

Unscheduled breakthrough bleeding and frequent spotting remain the primary complaints, caused by fluctuating hormone levels and the absence of stabilizing oestrogen.[6,10]

Advanced second- and third-generation POPs

The introduction of newer progesterone molecules has dramatically shifted patient preferences and expanded options.

Desogestrel (75 µg)

This formulation consistently inhibits ovulation as effectively as combined oral pills, while extending the missed-pill safety window to 12 hours.[7]

Drospirenone (4 mg)

Utilized in a unique 24/4 active-to-placebo regimen, drospirenone offers a highly forgiving 24-hour missed-pill administration window.[17]

Traditional progestin-only pills (POPs), such as norethisterone, have a 3-hour missed-pill window, which may increase user anxiety. Advanced POPs containing desogestrel provide a wider 12-hour missed-pill window, offering greater flexibility. Modern POPs containing drospirenone further extend this window to 24 hours, providing flexibility comparable to combined oral contraceptives (COCs).

Drospirenone acts as a selective aldosterone receptor antagonist with mild anti-androgenic properties, mirroring natural progesterone.[17] This unique profile helps minimize common progesterone-induced side effects, such as fluid retention, breast tenderness, and acne.[17]

Recent clinical surveys reveal high satisfaction scores for drospirenone-based POPs, driven by improved cycle control, a predictable bleeding profile, and reduced user anxiety regarding perfect-use compliance.[11,17] Furthermore, the ability to obtain POPs directly through direct pharmacy access channels in several countries lowers barriers to care, making oral options highly competitive for individuals who favour autonomy over procedural long-acting methods.[11]

SUBDERMAL CONTRACEPTIVE IMPLANTS: MAXIMUM EFFICACY AND THE BLEEDING PARADOX

The single-rod subdermal etonogestrel (ENG) implant (Implanon) is an exceptional long-acting reversible contraceptive (LARC), providing continuous protection for up to 3 years without requiring daily adherence.[10,15] Despite achieving perfect-use efficacy rates exceeding 99.9% due to its user-independent nature, the implant presents a unique clinical paradox regarding patient acceptability.[10,15]

Unpredictable bleeding and discontinuation rates

While the implant offers unmatched reliability, its primary challenge lies in cycle unpredictability. Continuous, low-dose release of etonogestrel can lead to variable patterns of endometrial sloughing.[10,14] Comprehensive health technology assessments and global clinical evaluations show that premature discontinuation rates for the ENG implant within the first year range from 15% to as high as 30% in certain cohorts, primarily driven by abnormal, prolonged, or unscheduled vaginal bleeding.[10,15,18]

A global meta-analysis indicates that while approximately 20% of users achieve favourable amenorrhea, up to 50% experience prolonged or frequent spotting episodes.[15,18]

Mitigating factors and clinical interventions

For users experiencing persistent, distressing bleeding, short-term therapeutic options include a 5-to-7-day course of low-dose combined oral contraceptives or non-steroidal anti-inflammatory drugs (NSAIDs) to temporarily stabilize the endometrial capillary network.[10] When managing these challenges effectively, the implant remains a highly attractive option for adolescents, young adults, and postpartum individuals seeking a discrete, exceptionally reliable method.[15]

LONG-ACTING INJECTABLE CONTRACEPTION: PRIVACY VERSUS SYSTEMIC SIDE EFFECTS

Depot medroxyprogesterone acetate (DMPA), administered either via a 150 mg intramuscular injection or a 104 mg subcutaneous formulation every 11 to 13 weeks, offers distinct benefits for specific patient cohorts.[6,8]

Key drivers of patient preference

DMPA is highly valued by patients prioritizing extreme privacy and discretion.[6] Because it requires no home storage and leaves no physical trace like a pill pack or a subdermal rod, it allows users to manage their reproductive health confidentially.[6] Furthermore, DMPA induces high rates of secondary amenorrhea, with roughly 46% of users achieving complete amenorrhea after one year of consistent use.[6,8] This provides excellent therapeutic relief for patients managing dysmenorrhea, menorrhagia, pelvic pain associated with endometriosis, or sickle cell crises.[6,8]

Significant clinical challenges

Despite these clear benefits, DMPA has one of the lowest long-term continuation rates among progesterone-only methods.[12] This low retention is driven by several distinctive clinical factors: delayed return to fertility, metabolic changes and weight gain, and bone mineral density (BMD) loss.

LEVONORGESTREL-RELEASING INTRAUTERINE SYSTEMS: THE GOLD STANDARD OF ACCEPTABILITY

The levonorgestrel-releasing intrauterine system (LNG-IUS) is available in various dosages, including the high-dose 52 mg system (Mirena) and lower-dose iterations like the 19.5 mg system (Kyleena). This modality represents a major advancement in balancing reliable contraception with high patient satisfaction.[16]

Localized action and superior efficacy

The primary clinical advantage of the LNG-IUS lies in its localized delivery mechanism.[16] By releasing levonorgestrel directly into the uterine cavity, it achieves high endometrial hormone concentrations while maintaining low systemic plasma levels.[16] This localized action suppresses endometrial proliferation and alters cervical mucus without systemically suppressing the HPO axis or lowering ovarian oestrogen production.[13,16] As a result, users rarely experience systemic side effects like mood swings, acne, or breast tenderness.[16]

High continuation rates and non-contraceptive benefits

Long-term health studies consistently rank the LNG-IUS at the top of patient satisfaction indices, with 12-month continuation rates frequently exceeding 80% to 85%.[9,12] While users may experience mild spotting during the first 3 to 6 months as the endometrium adjusts, this resolves into a significant reduction in total menstrual blood loss.[16] By the end of year one, up to 30–50% of 52 mg LNG-IUS users achieve amenorrhea.[16] This makes the system an effective first-line treatment for heavy menstrual bleeding (menorrhagia) and adenomyosis.[8,16]

Additionally, because the device does not cause structural or cellular changes, fertility returns to baseline immediately upon removal, providing an ideal combination of reliability, comfort, and safety.[13]

COMPARATIVE ANALYSIS OF LONG-TERM CONTINUATION RATES

A primary objective metric for evaluating contraceptive acceptability is the continuation rate at the 12-month and 24-month marks. Method retention serves as a direct indicator of user satisfaction, capturing the balance between a method's side effects and its convenience.[4,12]

Large-scale cohort tracking shows a distinct advantage for intrauterine systems.

LNG-IUS (80-85% retention)

Consistently exhibits the highest long-term retention. Its success is driven by minimal systemic side effects, high rates of light or absent menstruation, and the convenience of a single insertion.[16]

Etonogestrel implants (70-75% retention)

Show strong overall compliance due to their high objective efficacy. However, early discontinuation occurs primarily among users experiencing unpredictable, frequent, or prolonged bleeding patterns.[10]

DMPA injectables (50-55% retention)

Retention drops notably due to user hurdles such as scheduling clinic appointments every 3 months, combined with side effects like weight gain, persistent spotting, or mood changes.[6,8]

Table 2: Comprehensive clinical comparison of progesterone-only contraceptive delivery systems.

Delivery vehicle and system	Clinical efficacy (perfect versus typical use)	12-month continuation rate	Overall satisfaction rate	Primary drivers of patient acceptability	Core reasons for discontinuation/non-selection
Progesterone-only pills (POPs) (traditional norethisterone and modern drospirenone)	Perfect: 99.3%[7] Typical: 91.0%[12]	40–50%[6] (lowest across all modalities due to daily compliance barriers)	Moderate to high[11] (significantly optimized with novel 24/4 regimens)	Complete user autonomy and control; instant, non-clinical self-reversibility; non-invasive, procedure-free initiation; modern formulations offer a highly forgiving 24-hour missed pill safety margin[17]	Ongoing, daily user adherence burden; anxiety regarding typical-use failure; frequent unscheduled breakthrough bleeding and spotting; user-initiated cessation due to routine shifts[10]
Subdermal implant (etonogestrel 68 mg single-rod system)	Perfect: >99.9%[15] Typical: >99.9%[15]	70–75%[10] (high mechanical compliance but prone to early removal requests)	High[15] (exhibited primarily among users with stable bleeding patterns)	Long-term coverage (3 years continuous); completely decoupled from user compliance; rapid, immediate return to baseline fertility upon removal; highly discrete and private delivery system[13,15]	Unpredictable, prolonged, or frequent bleeding/spotting episodes (primary driver); requirement for minor in-office surgical insertion and removal procedures; localized insertion site anxiety or minor scarring[18]
Long-acting injectable (DMPA-IM 150 mg/DMPA-SC 104 mg)	Perfect: 99.8%[8] Typical: 94.0%[12]	50–55%[12] (retention limited by strict clinic re-visit dependencies)	Moderate[8] (highly polarized based on individual menstrual outcomes)	Maximum visual privacy; zero physical presence (no rod, no visible pill packs); high rate of secondary amenorrhea; significant non-contraceptive therapeutic relief for severe pelvic pain and dysmenorrhea[6,8]	Delayed return to regular fertility (mean of 7–10 months post-discontinuation); documented metabolic weight gain shifts; mood disturbances or unpredictable spotting; transient, reversible loss of bone mineral density (BMD)[6,8,13]
Intrauterine system (LNG-IUS) (high-dose 52 mg Mirena/low-dose 19.5 mg Kyleena)	Perfect: 99.8%[16] Typical: 99.8%[16]	80–85%[9,12] (highest sustained long-term retention in clinical cohorts)	Very high[16] (consistently ranks highest in longitudinal consumer surveys)	Localized endometrial therapeutic action resulting in minimal systemic side effects; up to 90% objective reduction in total menstrual blood loss (MBL); extended multi-year protection (3 to 8 years)[16]	Fear or experience of acute localized pain during uterine insertion; anxieties regarding pelvic infection or perforation; anatomical contraindications (uterine anomalies); spontaneous device expulsion risks (2–5%)[19,20]

Oral POPs (40-50% retention)

Show the lowest continuity rates over 12 months. This is rarely due to medical complications; rather, it stems from the daily discipline required for compliance and the ease of simply stopping the pill when breakthrough bleeding or schedule disruptions occur.[6]

STEP-BY-STEP COUNSELLING PROTOCOL

Establish baseline eligibility and safety: medical assessment

Review the patient's medical history against the WHO Medical Eligibility Criteria (MEC). Identify any definitive contraindications, such as active breast cancer, severe liver

disease, or acute thromboembolic events, to establish a safe selection pool.[10,11]

Explore menstrual priorities and non-contraceptive goals

Discuss the user's preferences regarding their menstrual cycle. Determine if secondary amenorrhea is a desired benefit (e.g., for managing dysmenorrhea or menorrhagia) or if unpredictable bleeding would cause significant anxiety or cultural disruption.[6]

Evaluate user autonomy versus lifestyle structure

Adherence readiness; assess the patient's daily routine to balance short-acting options against LARCs. For individuals with variable schedules, recommend advanced POPs or procedural LARCs to prevent typical-use failures from missed doses.[6]

Set detailed anticipatory side-effect expectations

Bleeding and fertility counselling; provide clear guidance on potential cycle changes. Emphasize that unscheduled spotting with implants or implants is an expected benign side effect, and explain the prospective return-to-fertility timeline for each modality.[10,13]

IMPACT OF ANTICIPATORY COUNSELLING

By employing this structured approach, healthcare providers can transform patient care. Shared decision-making ensures that patients select a method aligned with both their physiological needs and lifestyle goals.[1,2] When patients understand that bleeding changes are a benign, expected effect of endometrial remodelling, early discontinuation drops significantly, paving the way for superior reproductive autonomy and long-term satisfaction.[18]

CONCLUSION

Patient preferences and the long-term acceptability of progesterone-only contraception are determined by a complex interplay of pharmacological properties, lifestyle factors, and individual tolerances. LNG-IUS remains a highly valued option, blending localized endometrial action with high continuation rates and therapeutic benefits for heavy menstrual bleeding. Subdermal etonogestrel implants offer unparalleled contraceptive security, but their long-term success requires careful management of unpredictable bleeding patterns. While injectables (DMPA) provide valuable privacy and secondary amenorrhea, their use can be limited by metabolic changes, bone density considerations, and a delayed return to fertility. Meanwhile, the development of modern POPs, such as drospirenone, has refined oral options by offering a highly forgiving dosing window and improved cycle control. In conclusion, the available evidence demonstrates that acceptability of progesterone-only contraception is determined by far more than contraceptive efficacy alone. Menstrual experiences, convenience, fertility considerations, non-contraceptive benefits, perceptions of safety, and the quality of contraceptive counselling collectively shape patient satisfaction and continuation. Long-acting reversible contraceptives, particularly the LNG-IUS and etonogestrel implant, generally achieve the highest levels of continuation and satisfaction, although each progesterone-only method offers unique advantages that may align with specific patient priorities. Ultimately, the success of progesterone-only contraception depends upon the integration of evidence-based medicine with individualized, preference-sensitive, and autonomy-supportive contraceptive care. Such an approach remains fundamental to improving reproductive health outcomes and ensuring that women are empowered to make informed decisions regarding their contraceptive choices.

Ultimately, there is no single "ideal" progesterone-only contraceptive. True clinical excellence lies in matching each patient's unique physiological profile and personal goals with the most appropriate method. By providing thorough, proactive counselling regarding expected bleeding variations and lifestyle compatibility, healthcare providers can empower patients, improve method retention, and achieve excellent family planning outcomes.

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