Decision Making in Contraception

Consultation Essentials

Important Principles

- Contraception decision making is centred on informed choice by an individual who has been provided with accurate, evidence-based information on *all options*
- Combine effective listening with a knowledge driven approach
- Frame the discussion of choice around advantages and disadvantages of each method
- Relevant medical issues require early identification to refine suitable options
- Explore intentions and life plans in relation to pregnancy
- Discussions may occur in a variety of **contexts**

Contexts may include:

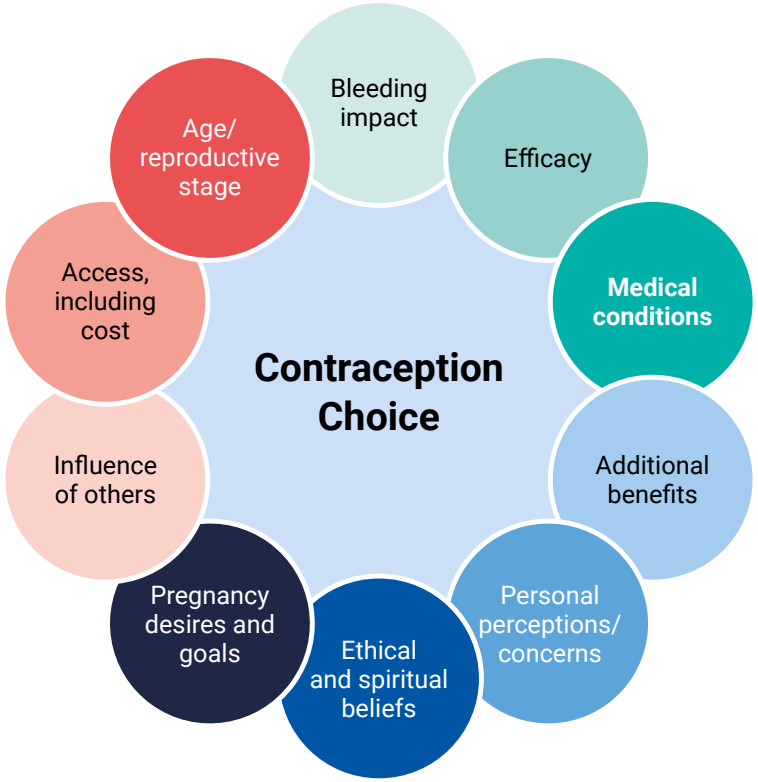
- Planned contraceptive options consultation
- Annual health checks for First Nations people
- Opportunistic e.g. perimenopause, travel health
- Post partum follow up
- Abortion consultation or follow up

- Involvement of others may contribute useful decision support, insights or information and/or highlight the importance of seeing an individual alone
- Consider the possibility of reproductive coercion (controlling or threatening behaviour by others) in contraceptive choices
- Meet contraceptive needs at each visit by providing written information, planning initiation of contraception, or immediate provision of a method
- Adapting style and content may be required with various **patient populations**
- Discuss contraception with people of diverse gender identities engaging in sexual activity that may result in pregnancy

Patient populations may include:

- Young people, Aboriginal and Torres Strait Islander peoples, trans and gender diverse people, culturally and linguistically diverse people

Patient Considerations



There are a wide range of individual factors and priorities in contraception choice for the individual/couple

Practitioner Considerations

- Factor in all patient considerations
- Medical history to identify contraindications and considerations including:
  - Menstrual disorders, acne, breastfeeding
  - Other non-contraceptive benefits
  - Risk factors for venous and arterial vascular disease (relevant to oestrogen containing methods)
  - Use of liver enzyme-inducing medications (relevant to all hormonal methods except DMPA and IUDs)
  - Significant medical risks of a pregnancy
- Use Medical Eligibility Criteria to guide safe choice
- Explore and challenge myths and misunderstandings
- Undertake opportunistic activities e.g. cervical and STI screening
- Provide initiation advice (Quick Start, Bridging, Dual protection) *For additional info please see next page*

Medical Eligibility Criteria (MEC)

- Classifies safety of contraceptive methods in individuals with specific medical conditions
- Risk of use is weighed against risk of pregnancy

MEC 1	No restrictions on method use
MEC 2	Advantages of method outweigh risks
MEC 3	Risks usually outweigh advantages. Seek expert opinion.
MEC 4	Unacceptable health risk (absolute contraindication)

For full details see FSRH website

Glossary

COCP	Combined Oral Contraceptive Pill	**HCP**	Health Care Practitioner	**PCOS**	Polycystic Ovarian Syndrome	**UPA**	Ulipristal Acetate
CVR	Combined Vaginal Ring	**HMB**	Heavy Menstrual Bleeding	**PID**	Pelvic Inflammatory Disease	**UPSI**	Unprotected Sexual Intercourse
DMPA	Depot Medroxyprogesterone Acetate	**IMI**	Intramuscular Injection	**PMDD**	Premenstrual Dysphoric Disorder	**VTE**	Venous Thromboembolism
DSP	Drospirenone	**IUD**	Intrauterine Device	**PMS**	Premenstrual Syndrome		
EC	Emergency Contraception	**LNG**	Levonorgestrel	**POP**	Progestogen Only Pill		
HCG	Human Chorionic Gonadotrophin	**NET**	Norethisterone	**STI**	Sexually Transmissible Infection		

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Choosing a Method: Advantages and Disadvantages

Long-Acting Reversible Contraception (LARC)

Fit and forget

>99% efficacy

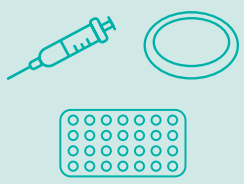
- ✔ Very long action - "fit and forget" for years
- ✔ Immediate return to fertility
- ✘ No STI protection
- ✘ Need HCP to insert & remove

Other Hormonal Methods

Very effective if used perfectly

93-99% efficacy

- ✔ Can be highly effective
- ✘ No STI protection
- ✘ Needs HCP to prescribe
- ✘ Potential for hormonal side effects



Barriers and Others

Less effective in typical use

76-99% efficacy

- ✔ Condoms are the only contraceptive that provides STI protection
- ✘ Lower efficacy in typical use - not recommended if unintended pregnancy risks medical or psychological harm

Sterilisation

Permanent

>99% efficacy

✔ ✘ Permanent

Efficacy†	Method	Advantages ✔	Disadvantages ✘
99.95%	**Progestogen Implants**	• Simple insertion procedure readily available in most primary care settings • Suitable for Quick Start • Amenorrhoea or infrequent bleeding in ~ 22% of users • Very few contraindications - current breast cancer is the only MEC 4 • MEC 1 immediately post partum, including breastfeeding	• Frequent and/or prolonged bleeding in ~ 25% of users • Medication interactions e.g. some anticonvulsants, rifampicin/rifabutin, some antiretrovirals
99.95%	**Intra Uterine Devices (IUDs)** - Levonorgestrel (LNG) - Copper	• Local (intrauterine) mechanism of action • MEC 1 for breastfeeding • Few contraindications – MEC 4 include current PID, unexplained abnormal bleeding and, for LNG only, current breast cancer • No medication interactions • Longest acting of reversible methods (5 or 10 years) **LNG IUD only:** • ~ 50% amenorrhoea at 12 months use • Non-contraceptive benefits e.g. for Mx of HMB, dysmenorrhoea and endometriosis • Minimal to no hormonal side effects **Copper IUD only:** • Immediately effective • Hormone free • Maintains regular monthly bleed for people who prefer this • Highly effective EC + provides ongoing contraception • 10 year efficacy for some devices	• Insertion requires internal vaginal speculum examination which may be difficult for some people, and the insertion procedure may be variably painful • Suitably skilled inserter not always available in primary care settings • Low risk of procedural complications e.g. vasovagal, PID, uterine perforation • Cannot Quick Start due to risk of harm to undetected pregnancy • May require testing for chlamydia and gonorrhoea prior to insertion **Copper IUD only:** • May increase menstrual bleeding • Not on PBS
96-99.8%*	**DMPA Injection**	• Few contraindications - current breast cancer is the only MEC 4 • No daily action required • Use is undetectable by others • ~ 50 - 70% amenorrhea at 12 months use • No medication interactions	• Delay in return of ovulatory cycles/fertility in some users • Unpredictable breakthrough bleeding pattern in some users • HCP administration of IMI • Can cause weight gain and bone density loss in some
93-99.5%*	**Combined Hormonal Contraception** - COCP - CVR	• User control of cycle and administration once prescribed • Non-contraceptive benefits e.g. for management of HMB, dysmenorrhoea, endometriosis, PMS, PMDD, acne, perimenopausal symptoms **CVR only:** • Monthly administration • Not affected by vomiting, diarrhoea or malabsorption	• Many more MEC 4 and MEC 3 conditions than LARCs and PO methods • MEC 4 conditions more common e.g. migraine with aura, smokers > 35 yrs, past or current VTE • Medication interactions e.g. some anticonvulsants, rifampicin/rifabutin, some antiretrovirals • MEC 4 for 3 weeks post partum or 6 weeks if breastfeeding **COCP only:** • Daily action required
	Progestogen Only Pill (POP) - Levonorgestrel and Norethisterone (LNG, NET) - Drospirenone (DSP)	• Very few contraindications - current breast cancer is the only MEC 4 • MEC 1 immediately post partum, including breastfeeding **LNG,NET only:** • Effective in 48 hours **DSP only:** • Prevents ovulation –missed pill rules apply if pill >24 hrs late • Beneficial effects on vaginal bleeding over time	• Daily action required • Medication interactions e.g. some anticonvulsants, rifampicin/rifabutin, some antiretrovirals **LNG,NET only:** • Missed pill rules apply if pill >3 hrs late • Unpredictable vaginal bleeding patterns
88-98%* 79-99%* 82-86%*	**Condoms** - male/external **Condoms** - female/internal **Diaphragm** - female/internal	• No HCP input required • Hormone free, no side effects or impact on cycles • Can use EC if required e.g. broken condom, barrier not used **Male condom only:** • Widely accessible • More effective than diaphragm and female condom **Condoms only:** • Effective protection against many STIs	**Male condom only:** • Not controlled by person at risk of pregnancy **Female condom and diaphragm:** • More expensive than male condom • Limited access **Diaphragm only:** • May need HCP to teach insertion and limited practitioner knowledge
76-99%*	**Fertility Awareness Based Methods (FABM)**	• Hormone free, no side effects or impact on menstrual cycles • May align with belief systems which restrict contraceptive options	• Significant commitment required to learn and to comply with periods of abstinence or use of barrier methods required for efficacy • Less suitable with irregular menstrual cycles
80-95%*	**Withdrawal**	• User controlled • Can use EC if method not adhered to	• No control for female partner • Lower efficacy especially in inexperienced
>99%	**Sterilisation** - Male (vasectomy)	• Can be done under local anaesthetic • Provided in some Primary Health/GP settings	• Needs post-op sperm count at 3 months to confirm effectiveness
	Sterilisation - Female (tubal ligation)	• Control by female partner • Potentially undetectable by others • No impact on menstrual cycle	• Surgery and general anaesthesia required • Public hospital access difficulties • No impact on menstrual cycle

† *Efficacy figures based on data from the Therapeutic Guidelines and UK Faculty of Sexual and Reproductive Health Care (FSRH)*

* *Efficacy rate variations in non LARC methods reflect difference in typical use and perfect use*

Commencing Contraception Methods

Key considerations:

- Exclude pregnancy/ recent conception risk
- Will the method be immediately effective?

A NEGATIVE pregnancy test (urine or serum HCG):

- *May not reliably exclude early pregnancy. To exclude undiagnosable early pregnancy including very recent conception, a careful menstrual, sexual and contraceptive history is required.*
- *Excludes early pregnancy ONLY if there has been NO UPSI in the 3 weeks preceding the test.*

Pregnancy risk can be excluded when a method is commenced in the following settings:

If	• Day 1 to 5 of a NORMAL menstrual period** • Within 21 days postpartum • Within 5 days of an abortion	Then	No additional contraception required
If	• No UPSI since Day 1 of last NORMAL menstrual period** • No UPSI in past 3 weeks and a urine HCG is negative	Then	7 days additional contraception/abstinence is required (except a copper IUD which is always immediately effective)
If	Currently reliably using an effective contraceptive method	Then	See Therapeutic Guidelines for more detail on switching between methods

See Therapeutic Guidelines for further information on initiating contraception methods and Quick Starting

** *A careful history is important to ensure that "a period" is normal menses, not an implantation bleed or other*

Quick Start

Quick Starting contraception: "Seize the Day"

- Consider "Quick Start" of a hormonal contraceptive at initial consultation, even if it is later than day 5 of the menstrual cycle. Balance the risk of an undetectable early pregnancy with the risk of unintended pregnancy while delaying starting.
- Suitable for all methods of contraception other than IUDs (hormonal and copper)
- Strongly encouraged when:
  - menstrual cycle is long or irregular e.g. PCOS
  - unintended pregnancy carries specific medical or psychosocial risks
  - access to health services (e.g. for insertion of an implant) is challenging

Share the "Quick Start" decision with the patient and discuss that:

- A follow up pregnancy test in 4 weeks is required (a formal recall is recommended)
- There are no known teratogenic effects from hormonal contraceptives (other than cyproterone acetate)
- 7 days of additional contraception/abstinence are required after starting

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Consultation Essentials

Young People and Contraception Consultations

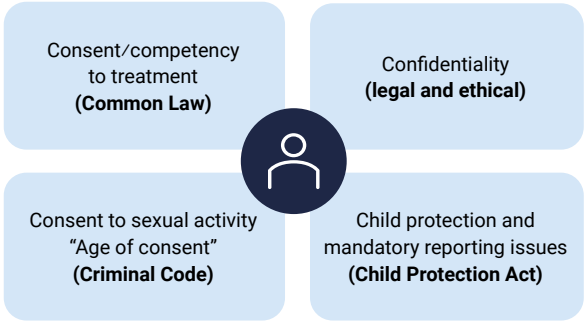
- Aim to see a young person on their own but encourage the involvement of significant adults, where appropriate, in decision making
- Discuss confidentiality explicitly
- Establish rapport and take a general history guided by a HEADSSS Assessment Framework
- Use the HEADSSS discussion to assist in assessing the competence of the young person to give consent/make informed decisions as a "mature minor"
- Seek support and advice from colleagues in assessing any child safety concerns in minors; be aware of specific state-based child protection reporting requirements
- Encourage use of LARCs as first choice
- Provide information on STIs; encourage condom use and STI testing
- Educate on EC and where it can be accessed

HEADSSS

- **H**ome
- **E**ducation, employment
- **A**ctivities
- **D**rugs and Alcohol
- **S**exuality and Gender
- **S**uicide, mental health
- **S**afety

Consider various legal responsibilities

These are often intertwined but should be considered separately – especially in complex cases



Emergency Contraception

- Can be used within 5 days of unprotected sex - after contraception failure (broken condom, missed pills) or when contraception has not been used at all, and after sexual assault
- Is very safe, has very few contraindications
- Is underutilised, possibly due to lack of community awareness of its availability

Health practitioners have a key role in raising awareness about EC and can provide an advance supply or advance prescription in some circumstances.

Methods of EC are:

- Oral hormonal EC [stat dose of either ulipristal acetate (UPA) 30mg within 120 hours or levonorgestrel (LNG) 1.5mg within 96 hours]: available from pharmacies without a prescription
- Copper IUD insertion: the **most** effective method of EC. It must be inserted by a trained clinician within 120 hours of unprotected sex

It is important that those not consistently using contraception, or using condoms and other less reliable methods, know how and where to access EC should they require it.

Choosing between EC methods

	Advantages ✔	Disadvantages ✘
Insertion of Copper IUD	• Most effective EC • Provides ongoing contraception • Efficacy unaffected by body weight or medication	• Requires trained provider with appointment availability • May be costly
EC pill - UPA 30mg - LNG 1.5mg	• Available from pharmacies **UPA only** • Most effective oral EC • Efficacy up to 120 hours **LNG only** • Not contraindicated during breastfeeding	• Efficacy may be reduced if BMI >30 or wt >85kg **UPA only** • Efficacy lowered by hormonal contraception in previous 7 or following 5 days

Additional Resources

Patient Education

- FPAA Efficacy Card
- Young people
- Family Planning Alliance Australia
- ACT - Sexual Health and Family Planning ACT (SHFPACT)
- NSW - Family Planning NSW
- QLD - True Relationships and Reproductive Health
- SA - SHINE SA
- VIC - Sexual Health Victoria
- WA - Sexual Health Quarters
- TAS - Family Planning Tasmania
- NT - Family Planning Welfare Association of NT Inc

Health Practitioner Guidance

- Contraception chapters of Australian Therapeutic Guidelines *(including detailed information on all methods and many specific topics e.g. MEC categories, missed pill rules, switching contraception methods, side effects management, contraception in patient populations and specific circumstances)*
- Medical Eligibility Criteria Summary Tables *UK FSRH*
- Contraception Guidelines *UK FSRH*
- Emergency Contraception Wheel
- Reproductive Coercion Information *Children by Choice*
- Sexual Health for Young People *STIPU*
- HEADSSS assessment:
  - Engaging with and assessing the adolescent patient
  - Conducting a Psychosocial Assessment
- Mandatory Reporting
- 1800 My Options - Phone number 1800 696 784
- QLD Abortion & Contraception Services Map *Children by Choice*

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