Implementation and Evaluation of a Learning Framework to Guide Evidence-Based and Patient-Centred Contraceptive Consultations

Alexandra Lipa[1], Sarah Maunsell[1], Cherie Bennett[1,2,3], Courtney Gibbs[1], Lona Brown[4], Sara Whitburn[4]

[1]ASHM Health, Sydney, Australia, [2]Sydney Sexual Health Centre, Sydney, Australia, [3]The Kirby Institute, UNSW, Sydney, Australia, [4]Sexual Health Victoria, Melbourne, Australia

Disclosure of Interest

This work was financially supported by Organon. Sponsorship is governed by ASHM's sponsorship policy. Organon had no control over content, tone, emphasis or allocation of funds. ASHM does not endorse or promote any sponsor's product or service.

Acknowledgements

Dr Caroline Harvey
SRH GP, Co-Director Iris Education

Cherie Bennett
Nursing Policy and Advocacy Lead & Medical Educator, ASHM
Clinical Nurse Specialist, Sydney Sexual Health Centre

Regan Chesterfield
Violence, Abuse and Neglect Forensic Nurse Examiner, Far West Local Health District

Dr Angela Smith
Senior Medical Officer, Metro North Sexual Health and HIV Service

Dr Alison Creagh
GP, Sexual Health Quarters

Dr Martina Mende
GP, Sexual Health and Family Planning

Dr Rachel Turner
GP, Synergy

Dr Sally Fry
GP, Coastal Family Health Practice

Joanne Perks
Nurse Practitioner, NSW Health Dillwynia Correctional Centre

Dr Karen Freilich
GP, Turn The Corner
Sexual Medicine & Therapy Consultant, Monash Health

Dr Lona Brown
Clinician and Medical Educator, Sexual Health Victoria

Dr Sara Whitburn
Medical Director, Sexual Health Victoria

Education and training

ASHM delivers practical, flexible, and high-quality education and training options for the health workforce across Australia, Asia and the Pacific, supported by a comprehensive suite of guidelines and resources to meet the specific needs of the HIV, viral hepatitis, and sexual and reproductive health workforce.

Our education is highly valued by the health workforce, built on established principles of adult learning and delivered using a multi-modal learning approach including interactive online learning, practical case studies and peer-based learning.

Our key program areas

HIV

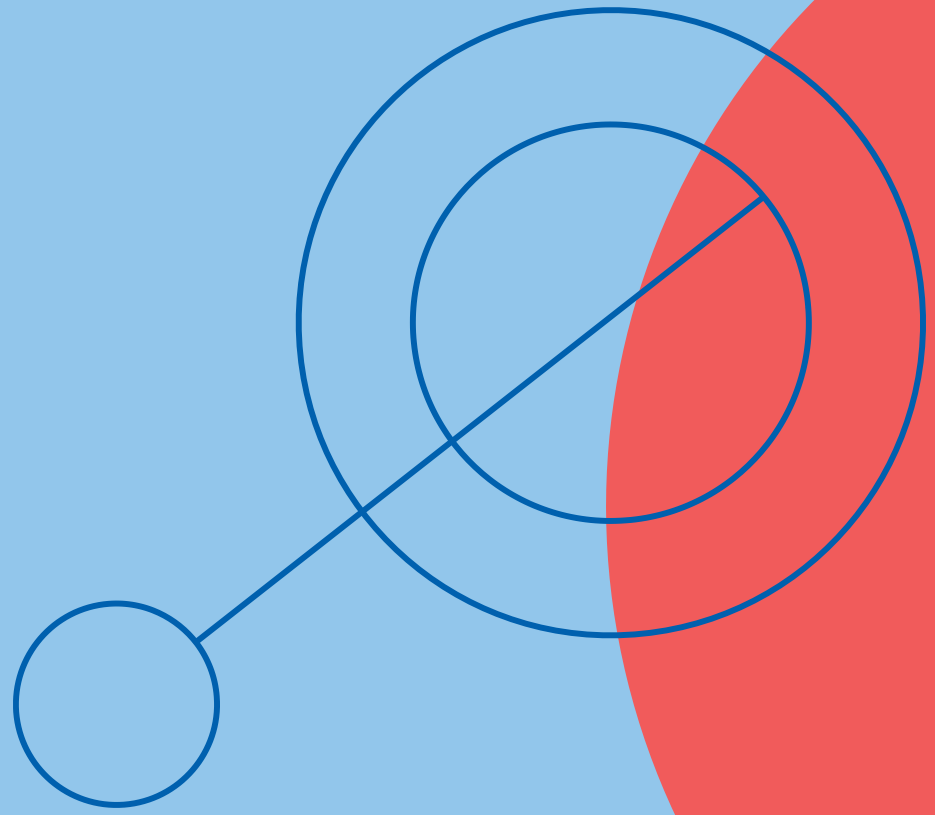
Hepatitis B

Hepatitis C

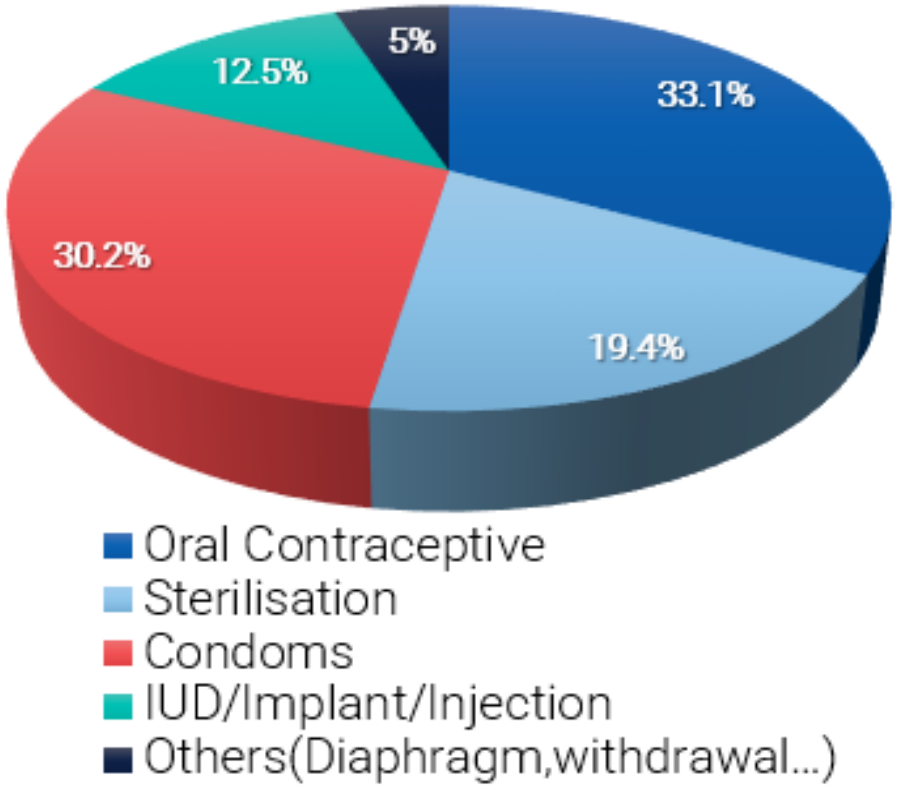
Sexual & reproductive health

ashm

Contraception in Australia

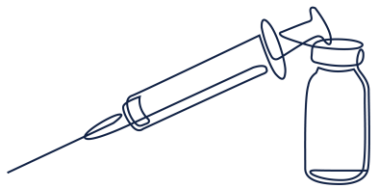


Contraceptive choice in Australia (16 – 49 yrs) 2012 - 2013



Richters et al., 2016; Trinh LT et al., 2016.

LARCs



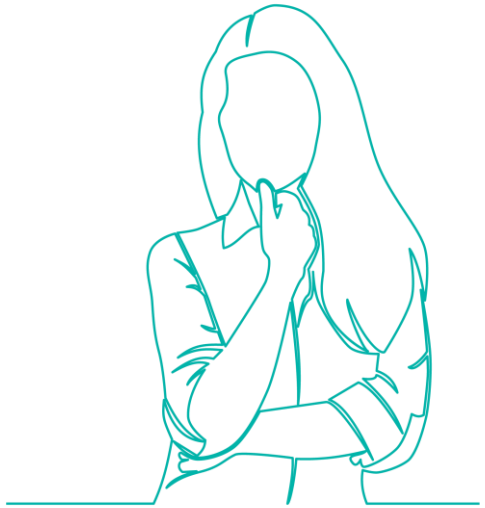
Long-Acting Reversible Contraceptives (LARCs)
> 99% effective at preventing pregnancy

Uptake remains low in Australia

Largely attributed to misconceptions among primary care providers

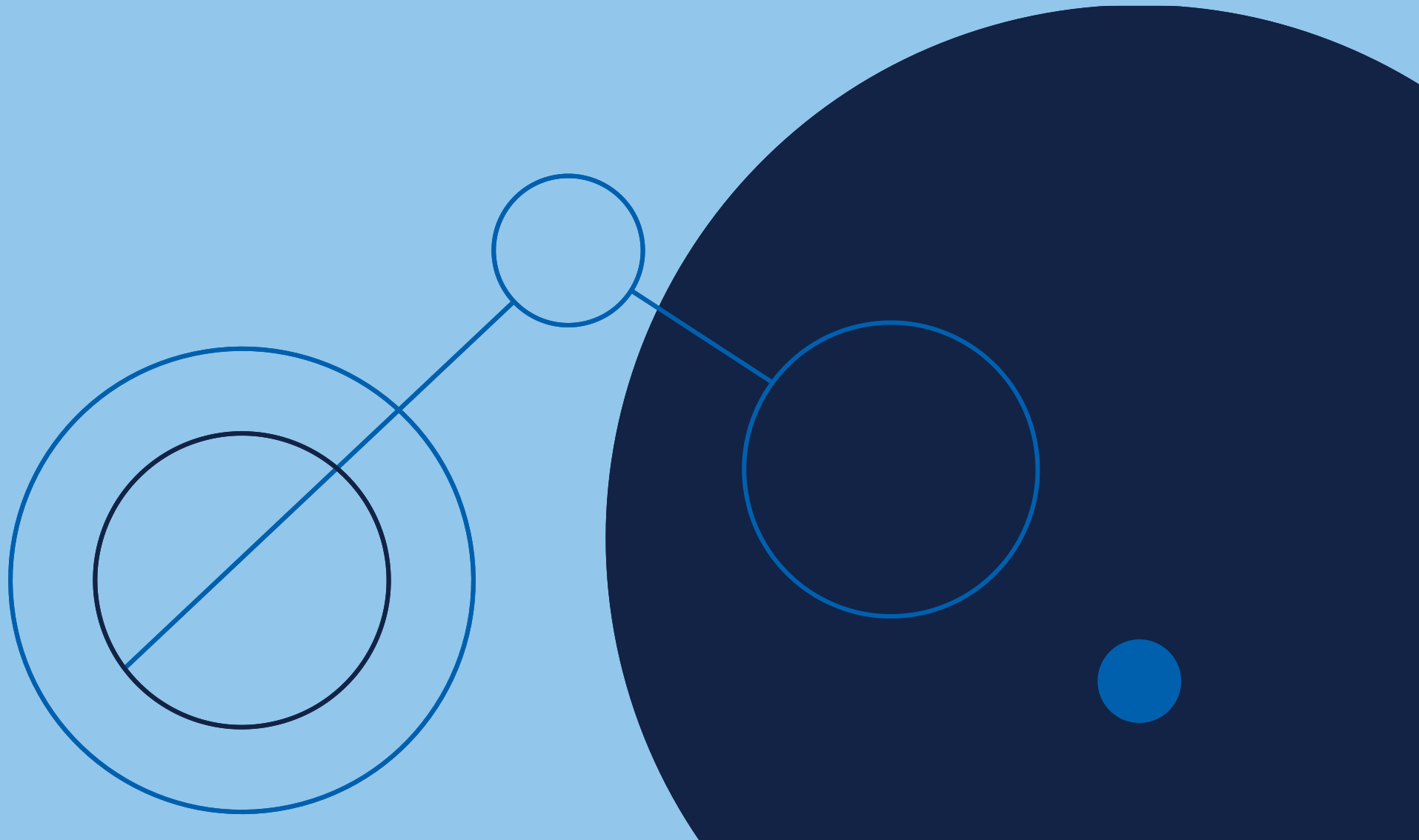
FSRH Guideline, 2023; Skiba et al., 2019; Haas et al., 2022; Holton et al., 2015; Linton et al., 2022

Needs Assessment



- 119 ASHM course participants
- Knowledge gaps in the counselling and provision of contraception

What did we do?



Decision Making in Contraception

Consultation Essentials

Important Principles

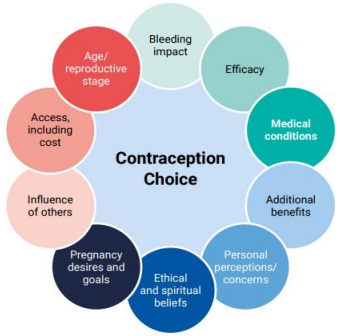
- Contraception decision making is centred on informed choice by an individual who has been provided with accurate, evidence-based information on *all options*
- Combine effective listening with a knowledge driven approach
- Frame the discussion of choice around advantages and disadvantages of each method
- 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		

Decision Making in Contraception

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
- Home
- Education, employment
- Activities
- Drugs and Alcohol
- Sexuality and Gender
- Suicide, mental health
- Safety

Consider various legal responsibilities
These are often intertwined but should be considered separately – especially in complex cases

- Consent/competency to treatment **(Common Law)**
- Confidentiality **(legal and ethical)**
- Consent to sexual activity "Age of consent" **(Criminal Code)**
- Child protection and mandatory reporting issues **(Child Protection Act)**

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*

*ASHM is grateful to Organon for an unrestricted educational grant which assisted in the development of this resource. The sponsor has no control over content, tone, emphasis, allocation of funder selection of recipients. ASHM does not endorse or promote any sponsor's product or service. **Disclaimer:** Guidance provided on this resource is based on guidelines and best-practices at the time of publication.*

ISBN: 978-1-921850-57-8

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IRIS EDUCATION Reproductive and sexual health education for health professionals

Decision Making in Contraception

Consultation Essentials

Choosing a Method: Advantages and Disadvantages

Efficacy*	Method	Advantages ✓	Disadvantages ✗
Long-Acting Reversible Contraception (LARC) *Fit and forget* **>99% efficacy** ✓ Very long active - 'fit and forget' for years ✓ Immediate return to fertility ✗ No STI protection ✗ Need HCP to insert & remove			
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 ~ 2-3% 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:** • ~ 80% 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
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			
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 IM • Can cause weight gain and bone density loss in some
93-99.3%*	**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
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			
88-98%*	**Condoms** - male/external	• 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
79-99%*	**Condoms** - female/internal		
82-86%*	**Diaphragm** - female/internal		
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
Sterilisation *Permanent* **>99% efficacy** ✓ ✗ Permanent			
>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 post-partum • 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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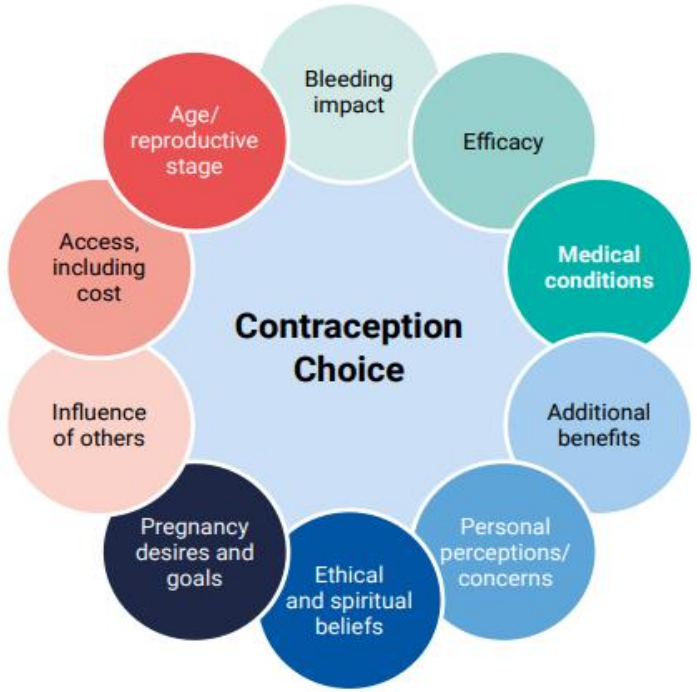

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Barriers and Others

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76-99% efficacy

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- ✗ Lower efficacy in typical use - not recommended if unintended pregnancy risks medical or psychological harm

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Sterilisation

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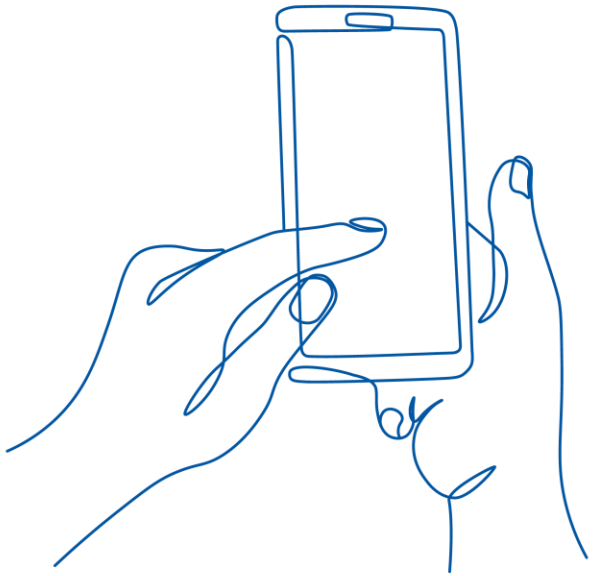
Live-facilitated training

- Free interactive training course delivered online, nationally
- Expanded on the tool
- Case studies to address learner-identified knowledge gaps

Roleplay video

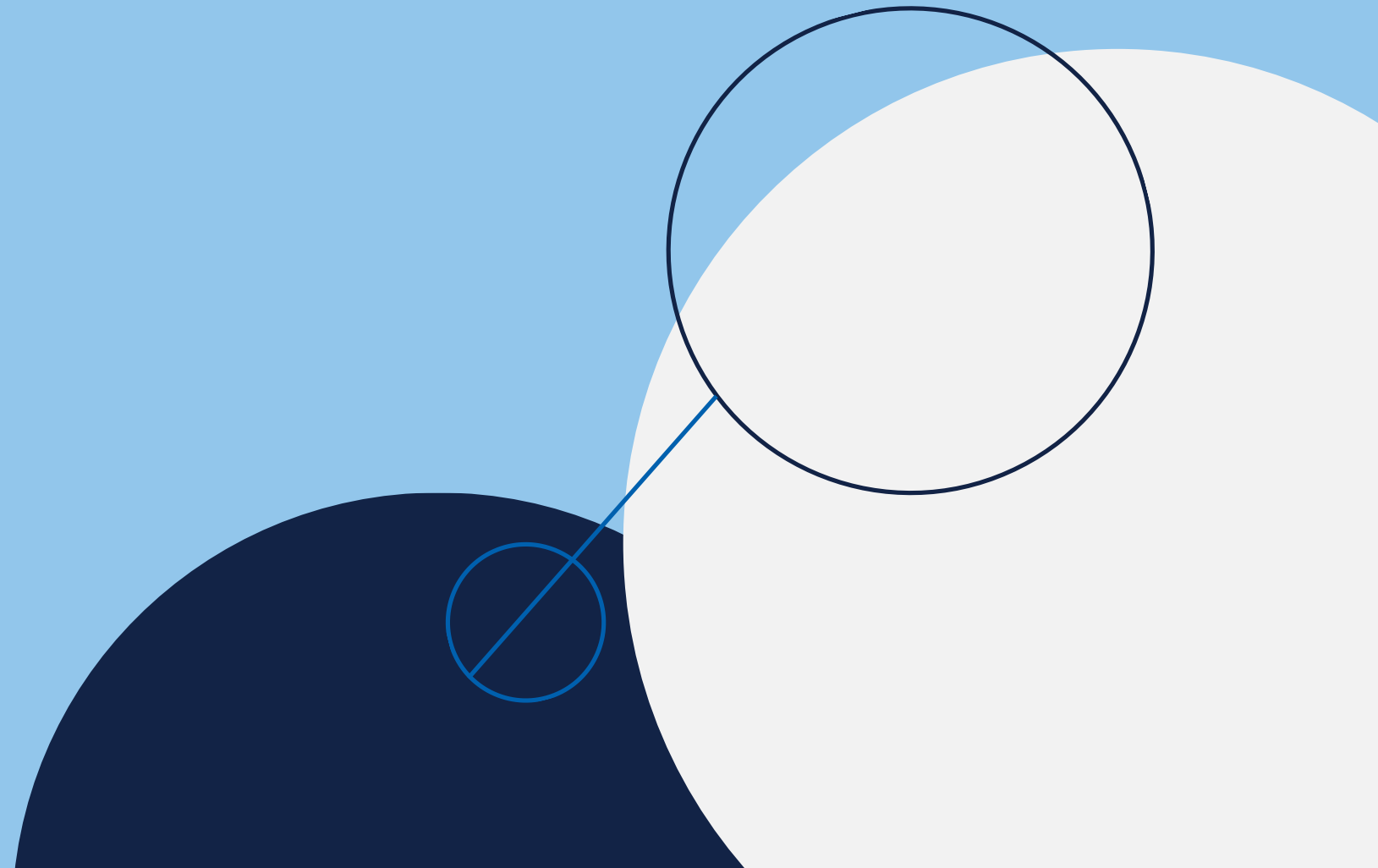
- Demonstrates best-practice contraceptive consultation
- Guides viewers on how to utilise the tool during a consultation

Online Learning Module

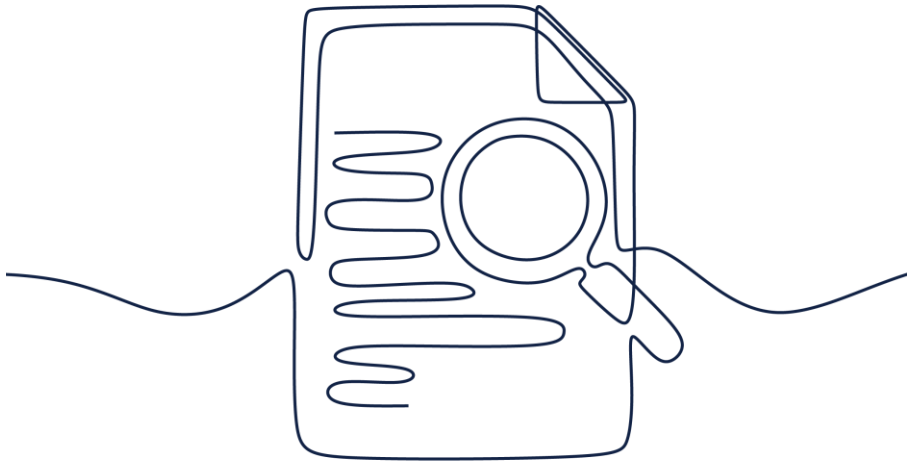


- 2-hour e-learning
- Increased accessibility

What did clinicians think?

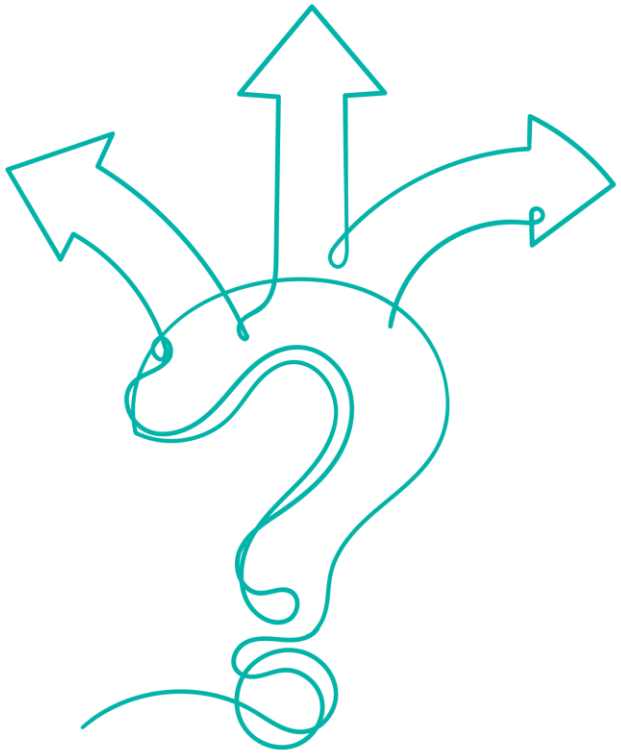


Engagement



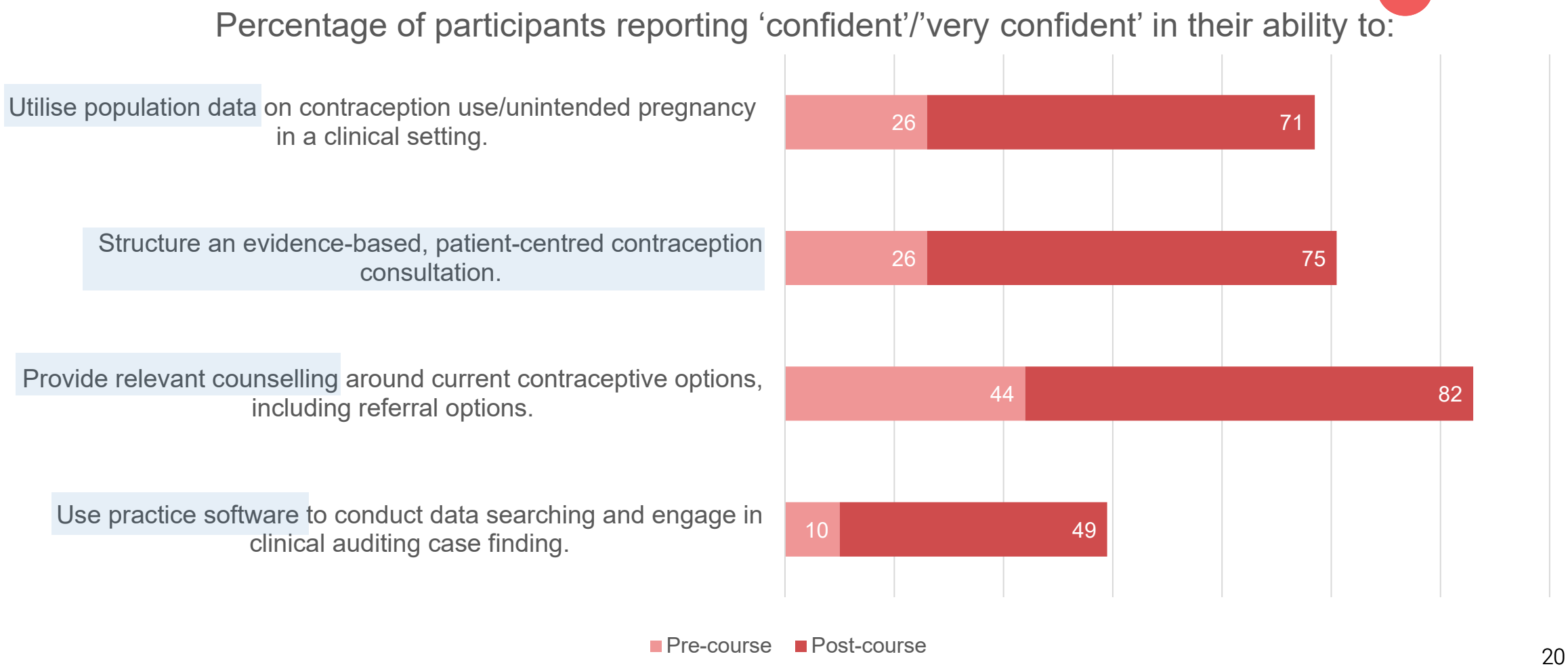
- > 5,000 unique visits to DMT webpage
- 363 course participants in 2023 and 2025
- 580 video views + 3,000 views on social media

Motivation



- 50% to “develop knowledge and expand scope of practice”
- 33% to “provide better patient care”
- 16% to “keep up to date with contraception information”

Course evaluation



Takeaways from the course

“Balancing efficacy and patient preference”

“I have gained more confidence”

“Discussing balanced shared discussion making”

“Clarity on contraception options. Great structure for a consult”

“I have used the decision-making tool to prompt the discussion with patients and to show patients the efficacy of different contraception options”

Changes in their practice

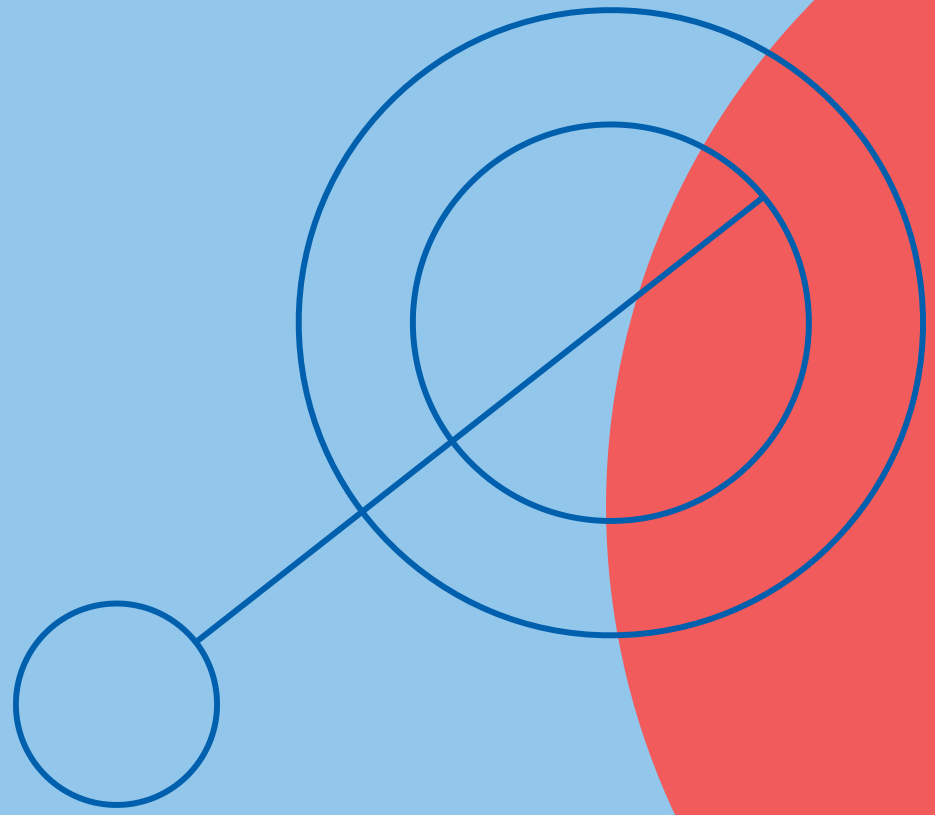
“Definitely debunking contraception myths is the biggest one”

“Use of UKMEC calculator to assess the risk/suitability of contraceptive options. Increased initiation of discussion of LARC options”

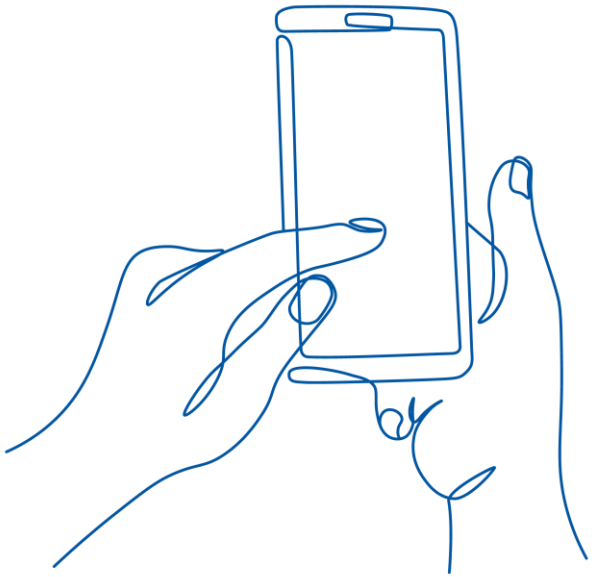
“More confident in my knowledge of options and their place in practice”

“I feel more confident in recommending contraception options”

What’s next?



Upcoming resources & training



- Gender-Affirming Contraception Decision Making Tool
- Sexual and Reproductive Health for Pharmacists Decision Making Tool
- Biannual delivery of live-facilitated course in 2025 – 2027
- Online Learning Module adaptation of ASHM's SRH for Pharmacists live-facilitated course
- LARC Quality Improvement Clinical Audit

Access the Decision Making in Contraception tool and other key resources here:

ashm.org.au/contraception-essentials

Alexandra Lipa – Senior Project Officer, ASHM

Alexandra.lipa@ashm.org.au

References

FSRH Guideline (March 2023) Intrauterine Contraception. *BMJ Sexual & Reproductive Health 2023*; 49:Suppl 1. Published https://srh.bmj.com/content/49/Suppl_1. doi: 10.1136/bmjsrh-2023-IUC

Haas, M, Church J, Street DJ, Bateson D, Fisher J, Taft A, Black KI, et al. 2022. "The Preferences of Women in Australia for the Features of Long-Acting Reversible Contraception: Results of a Discrete Choice Experiment." *The European Journal of Contraception & Reproductive Health Care* 27 (5): 424–30. doi:10.1080/13625187.2022.2098947.

Holton S, Rowe H, Kirkman M, Jordan L, McNamee K, Bayly C, McBain J, Sinnott V, Fisher J. 2015. "Long-Acting Reversible Contraception: Findings from the Understanding Fertility Management in Contemporary Australia Survey." *The European Journal of Contraception & Reproductive Health Care* 21 (2): 116–31. doi:10.3109/13625187.2015.1052394.

Linton E, Mawson R, Hodges V, et al "Understanding barriers to using long-acting reversible contraceptives (LARCs) in primary care: a qualitative evidence synthesis." *BMJ Sexual & Reproductive Health 2023;49:*282-292. https://doi.org/10.1136/bmjsrh-2022-201560

Richters, J., Badcock, P. B., Simpson, J. M., Shellard, D., Rissel, C., de Visser, R. O., & Grulich, A. E. (2016). Contraceptive practices among a representative sample of women: A study from the Australian Longitudinal Study on Women's Health. *Australian and New Zealand Journal of Public Health, 40(2),* 185-191. https://doi.org/10.1111/1753-6405.12501

Skiba MA, Islam RM, Bell RJ, Davis SR. "Hormonal contraceptive use in Australian women: Who is using what?" *Aust N Z J Obstet Gynaecol*. 2019;59(4):588-594. doi:10.1111/ajo.13021

Trinh, L. T., Wong, F. Y., & Freeman, E. (2016). Contraceptive use in women at risk of unintended pregnancy. *Australasian Epidemiologist, 23(1)*, 30-35.