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List of Acronyms

ASM – Annual Scientific Meeting

BPAS – British Pregnancy Advisory Service

CU IUD – Copper Intrauterine Device

FPA – Family Planning Association

FSRH – Faculty of Sexual and Reproductive Healthcare

GRADE – Grading of Recommendations, Assessment, Development and Evaluation

IHV – Institute of Health Visiting

IUD – Intrauterine Device

IUS – Intrauterine System

JLA – James Lind Alliance

LARC – Long-acting reversible contraception

NETSCC – National Institute for Health and Research Evaluation, Trials and Studies Coordinating Centre

NFP – Natural Family Planning

NIHR – National Institute for Health Research

PCWHF – Primary Care Women's Health Forum

POP – Progestogen-only pill

PSP – Priority Setting Partnership

RCOG – Royal College of Obstetricians and Gynaecologists

RSE – Relationships and sex education

SLE – Systemic lupus erythematosus

TRIP – Turning Research Into Practice Database

Acknowledgements

We thank the Contraception PSP Partners, Steering Group and all those who participated in the priority setting process.

Supporting Partners



The Palatine Centre,
Manchester



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Executive Summary

Most women spend at least 30 years of their lives avoiding unintended pregnancy. Improved access to contraception has revolutionised women's lives, allowing them to pursue education, careers and families on their own terms and in their own time. Yet, as contraceptive care evolves, many questions remain unanswered by research.

Collaboration for choice

We know that there is often a mismatch between what service users and healthcare professionals would like to know and the research that is actually undertaken. The aim of the Contraception Priority Setting Partnership (PSP) was to create a 'Top 10' list of research uncertainties for contraceptive care, identified and prioritised by service users, their partners and healthcare professionals. The purpose of the PSP is to inform policy-makers, commissioners, research funders, clinicians and the public about the research priorities of service users and healthcare professionals at the frontline of clinical care, ultimately enabling more informed choice and delivery of high-quality contraceptive services.

Overview of the process

The Contraception PSP was led by the Faculty of Sexual and Reproductive Healthcare (FSRH) and guided by the James Lind Alliance (JLA), a non-profit coordinated by the National Institute for Health Research (NIHR). FSRH recognised the need for

a more systematic approach to determine the kind of research that healthcare professionals and service users would like to be undertaken in the field of contraceptive care. To achieve this, FSRH followed the JLA priority setting process¹, which was established several years ago to involve patient / service users and clinicians – the end users of research – in determining the research agenda.

Through a robust process over 18 months, the JLA methodology led to a 'Top 10' list of priorities for contraceptive research:



The 'Top 10' unanswered research priorities for contraceptive care

1.

Which interventions (decision support aids, ease of access, motivational interviewing) increase uptake and continuation of effective contraception including long-acting methods (implants, injections and intrauterine contraceptives)?

2.

What is the risk of side effects (vaginal bleeding, mood, weight gain, libido) with hormonal contraception (pills, patches, rings, implants, injections and hormonal intrauterine system)?

3.

What are the long-term effects of using contraception (pills, patches, rings, injections, implants, intrauterine) on fertility, cancer and miscarriage?

4.

What models of care increase access and support decision-making for vulnerable groups (such as young people, people who don't speak or read English)?

5.

Which interventions are safe and effective for women who have irregular bleeding on long-acting hormonal contraception?

7.

What are the risks or benefits to using combined hormonal contraception (pill, patch or ring) continuously to stop or reduce periods?

8.

What factors (advice from friends, family, professionals, beliefs, experience) influence women making decisions about contraception?

9.

Are there tests or factors such as age that can reliably identify women who no longer require contraception around the menopause (including women using methods which can stop periods such as implants, hormonal coils, pills)?

10.

Are there effective new methods of hormonal contraception available for men?

Introduction

Despite the fact that contraceptive care is relevant to 51% of the population for almost a third of their lives², the medical specialty that covers contraceptive care – known amongst healthcare professionals and policy makers as Sexual and Reproductive Healthcare – is relatively young. Consequently, its research culture is still emerging, with scope for more direction to improve the quantity and quality of research into contraceptive care.

It is hard to overestimate the impact of modern contraception on women's health and livelihoods. Access to contraceptive care has enabled millions of women to choose whether and when to have children. Yet, in a landscape where the provision of, and access to, contraception has undergone many changes, there are many unanswered questions about contraceptive care that concern service users and healthcare professionals.

The changing landscape of contraceptive care is illustrated by the following factors:

- ▶ **There have been huge cuts to the public health budget that funds contraceptive care, resulting in 3.9 million women of reproductive age in England living in areas with some form of restriction to contraceptive care, due to either age or place of residency³** – this has impacted on the way people access contraceptive care, how services are delivered and the range of contraception provided.
- ▶ **New methods of contraception have been developed and more women are using long-acting reversible methods (LARC).** In 2015/16, 38% of women attending specialist SRH services were using long-acting reversible methods of contraception⁴; many women now have more questions about the impact of these methods on their health.

- ▶ **Advances in technology** – the 'one-click' culture in which we live means that service users can easily access information about contraceptive choices. It also means that services can be delivered in different ways, such as ordering contraception online from community pharmacists or booking appointments.
- ▶ **Increase in desire to be health literate** – there is an increasing desire among the public for straightforward information about the risks and benefits of contraception and how they affect their wider health.
- ▶ **Media coverage** – contraception attracts wide coverage in the media regarding its potential risks and benefits; both service users and healthcare professionals have questions arising from these stories that they want research to answer.



Professor Judith Stephenson

With this in mind, in November 2015 Professor Judith Stephenson approached the FSRH and the JLA to set up a Contraception Priority Setting Partnership to consult both service users and healthcare professionals as to the questions they would like to see contraception research answer. Speaking about why she chose to follow the JLA priority setting process, Professor Judith Stephenson said:

"The JLA process presents a unique and robust opportunity to engage with the two groups of people at the heart of contraceptive care; those receiving contraceptive care and the healthcare professionals who work so hard to enable women to exercise informed choices over their reproductive health.

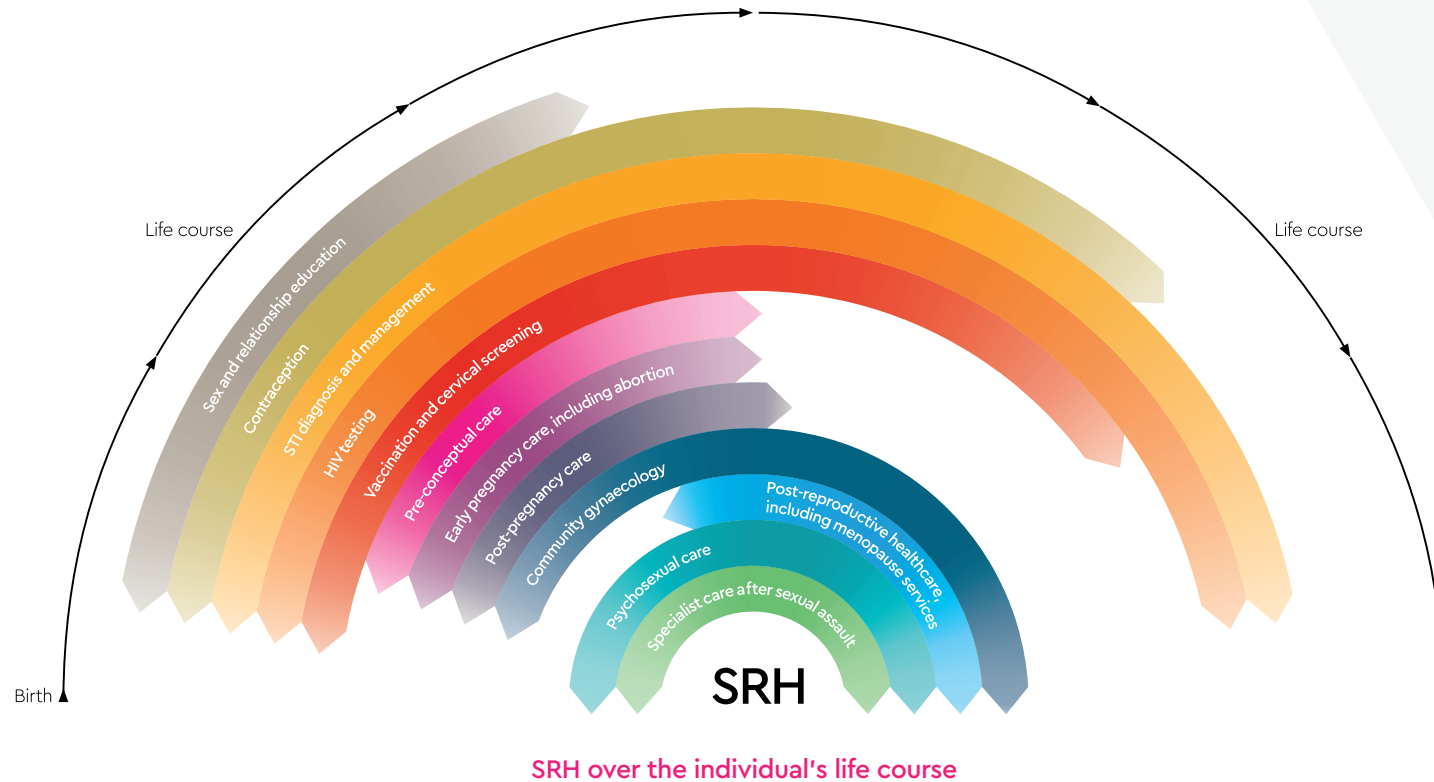
The successful delivery of contraceptive care relies on clear lines of communication between service users and their healthcare professionals. When I thought about this, I asked myself why we don't

replicate this collaborative process in setting research priorities for contraception, as these areas of research will ultimately affect both of these groups.

The JLA priority setting process provides us with the opportunity to do just that; bridging the gap that exists between research and those who deliver and receive contraceptive care, giving those at the heart of contraception the opportunity to shape the reproductive choices of the future."

Project Scope

Contraceptive care is a key component of SRH and an important part of women's lives across all stages of the life course.



After considerable discussion, the Steering Group defined the scope of contraceptive care, for the purposes of this project, as encompassing:

- ▶ Methods of contraception and their risks and/or benefits
- ▶ Accessing contraception
- ▶ Information about contraception
- ▶ Starting, switching, stopping or continuing contraception

JLA Methodology

The Contraception PSP followed the JLA methodology and framework to arrive at its 'Top 10' priorities for research in contraceptive care.

Below is a summary of the stages involved:

1

Creating the Contraception Priority Setting Partnership

- ▶ Steering Group establish Protocol and scope agreed
- ▶ Project timeline agreed
- ▶ Partners approached
- ▶ Official launch in November 2015

2

Initial survey

- ▶ Steering Group design survey
- ▶ Survey launched April 2016
- ▶ Partners and Steering Group promote survey on social media, websites, targeted communications and in waiting rooms
- ▶ "Tell us the questions you want contraception research to answer"

3

Data analysis

- ▶ Survey closed July 2016, with approximately 582 questions submitted by 207 people
- ▶ Questions grouped into themes, based on population, interventions and outcomes
- ▶ Out of scope questions removed, overlapping questions combined
- ▶ 83 summary (indicative) questions
- ▶ Search for guidelines, systematic reviews and randomised control trials to see if questions had already been answered by high quality evidence
- ▶ Long list of 57 verified research uncertainties established (unanswered questions)

Disseminating the findings

- ▶ 'Top 10' research priorities for contraceptive care launched at FSRH Annual Scientific Meeting (ASM) on 27–28 April 2017 in Cardiff
- ▶ Dissemination of findings and final report to media, decision makers and other relevant stakeholders
- ▶ Final report available on FSRH and Contraception PSP websites
- ▶ Final spreadsheet available on JLA website. For more information please read the JLA Guidebook
- ▶ Feeding into National Institute for Health and Research (NIHR) research setting agenda.

5

Final prioritisation workshop

- ▶ Workshop held on 21st April 2017 at Royal College of Obstetricians and Gynaecologists (RCOG) in London
- ▶ Attended by service users and healthcare professionals, facilitated by JLA
- ▶ A day of group discussions and ranking exercises to put the 29 questions in priority order

4

Interim prioritisation

- ▶ Second survey launched to rank the 57 questions, February 2017
- ▶ Healthcare professionals, service users and partners asked to choose and rank their top 10 questions
- ▶ Questions were given a score based on how they were ranked
- ▶ Top 29 highest scoring questions taken to final workshop for prioritisation

Stage 1: Creating the Contraception Priority Setting Partnership (PSP)

The Steering Group was made up of patient and service user representatives with an interest in contraceptive care, healthcare professionals involved in the delivery of contraceptive care, researchers, a data manager and a JLA advisor.

Healthcare professionals came from the following backgrounds and care settings:

- ▶ Primary care; e.g. general practice
- ▶ Specialist sexual and reproductive healthcare services
- ▶ Specialist young people's sexual and reproductive healthcare services
- ▶ Midwifery
- ▶ Nursing
- ▶ Obstetrics and gynaecology
- ▶ Junior doctors

Patients were represented by members from the following organisations:

- ▶ Brook
- ▶ FPA
- ▶ RCOG Women's Network
- ▶ FSRH
- ▶ Independent patient representatives with a specialist interest in contraception

The Steering Group was chaired by the JLA Advisor, Katherine Cowan.

A number of partner organisations actively promoted the Contraception PSP and encouraged participation in the process across their networks.

The Contraception PSP was formally launched at a meeting of the FSRH Council in November 2015.

PSP Partners:



**The Palatine Centre,
Manchester**



Stage 2: Initial Survey

From April to July 2016, the Contraception PSP ran a survey asking service users, their partners and healthcare professionals what questions they wanted research to answer. PSP partners promoted the survey (Appendix 1) on their websites and via social media to reach healthcare professionals and service users across a range of demographics, care settings and countries.

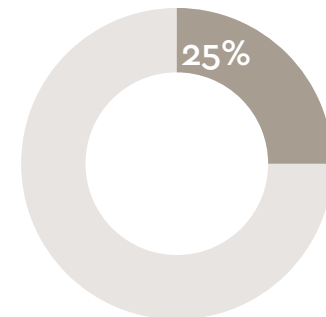
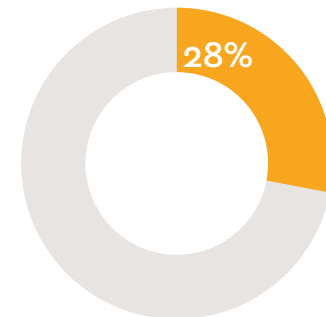
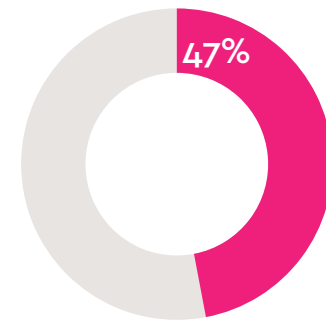
Respondents were asked to indicate whether they or their partner used contraceptive services, whether they were a healthcare professional providing contraceptive services or a member of the public with an interest in contraception.

"Tell us the questions you want contraception research to answer"

Respondents were asked to provide questions in 5 areas in contraceptive care:

- ▶ Questions about how someone accesses contraception
- ▶ Questions about how someone gets information in order to choose a type of contraception that suits them and their partners
- ▶ Questions about the benefits, risks or side effects of any particular types of contraception
- ▶ Questions about how someone chooses to start or stop a type of contraception
- ▶ Questions about how a person decides whether to continue a type of contraception or switch to another method of contraception

In total, 207 people responded to the survey. Almost half (47%, n=97) identified as people who use contraception or their partners. Around 28% (n=59) indicated they were healthcare professionals providing contraception services in general practice, community clinics or specialist services (such as nurses, midwives, doctors and healthcare support workers) and 25% (n=51) identified as both a healthcare professional and a user of contraceptive services. A total of 582 potential research questions were submitted.



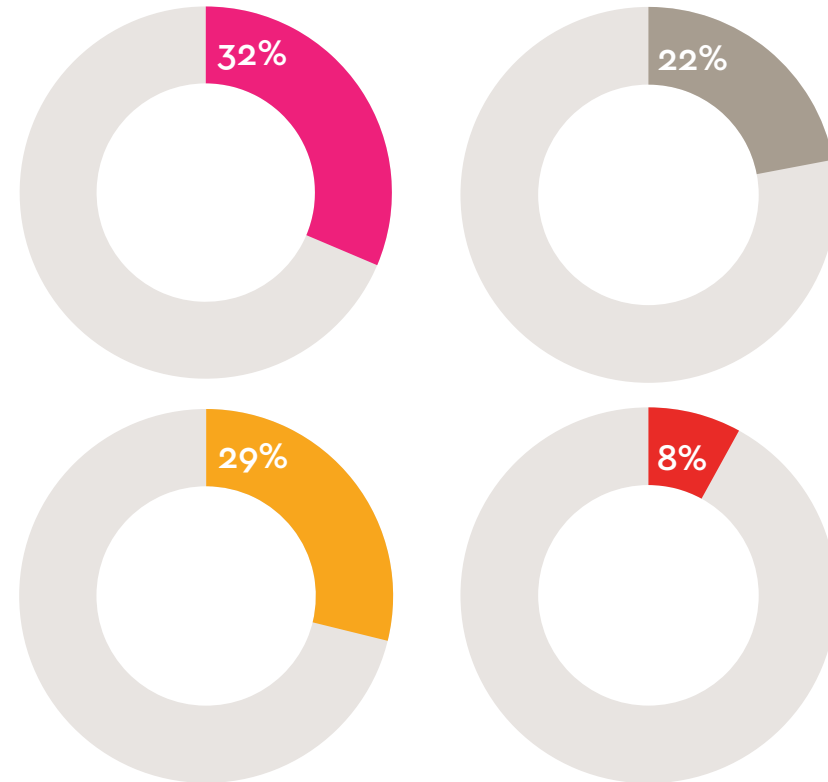
Total respondents = 207

- Contraceptive users or their partners
- Healthcare professionals
- Both healthcare professionals & users

86% of respondents were women.

8% were aged 16–24 years, 32% were aged 25–34 years, 22% between 34 and 45 years and 29% over 45 years old.

Around 4 out of 5 respondents self-identified as White, 77% were from England, 8% from Scotland and 4% from Wales.



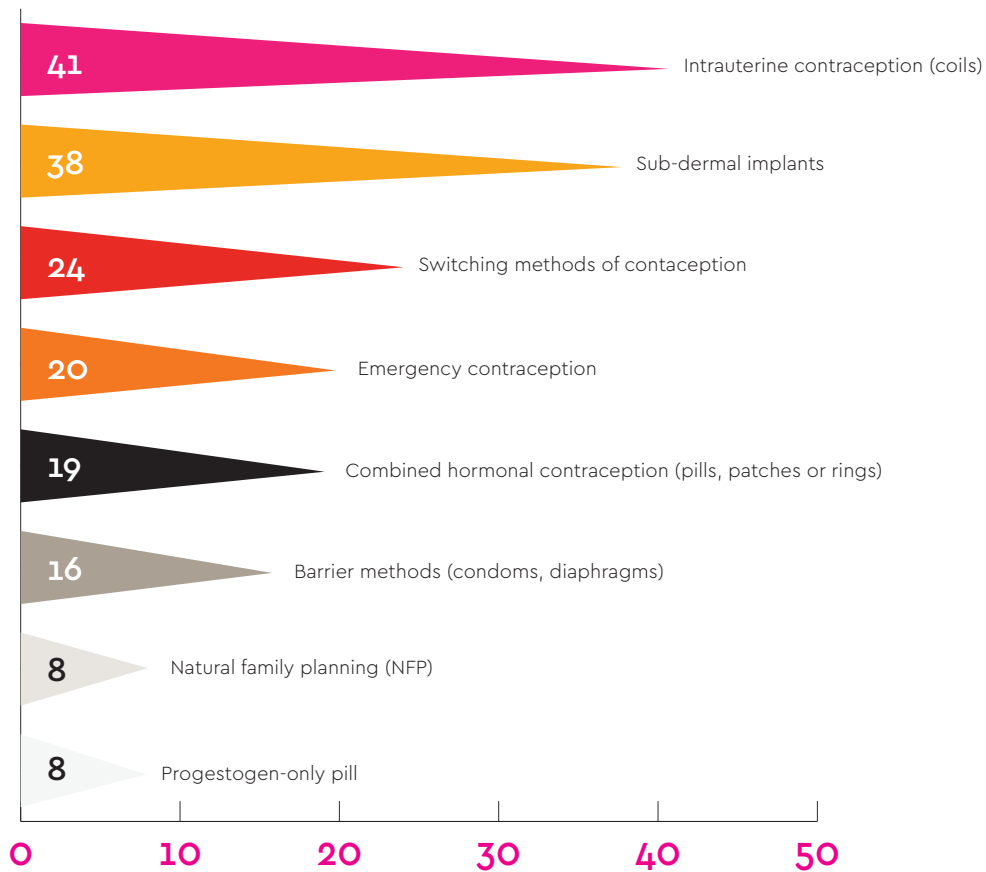
Age of respondents

- 25-34
- 45 & above
- 34-45
- 16-24

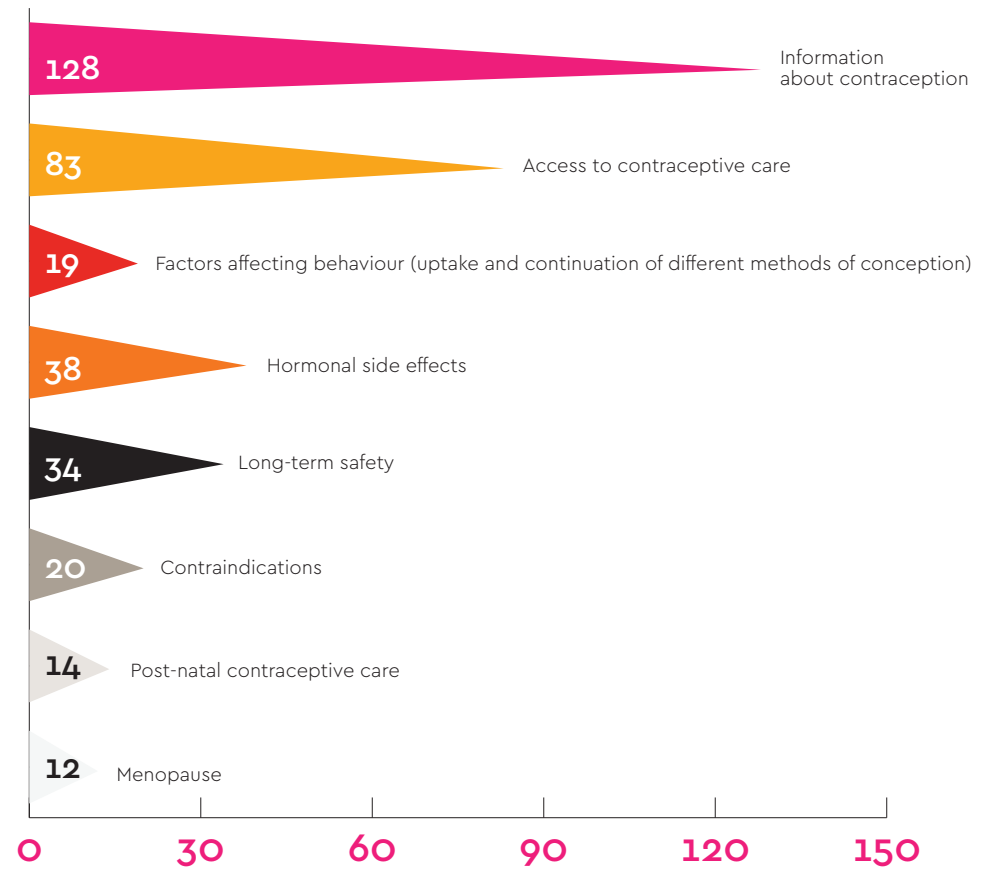
Stage 3: Data Analysis

Once the initial survey had closed, all questions were reviewed and grouped into broad themes. The number of questions submitted in each category is given below.

Contraceptive methods (Interventions)



Organisation and services, outcomes and specific population groups



Out-of-scope questions

Questions that fell outside of the scope of the project were identified – for example, questions on relationships and sex education (RSE) in schools.

Examples of out-of-scope questions included:

"How do I know which contraceptive pill my girlfriend should use?"

"I am interested in finding out more about female sterilisation"

"Are GPs paid to recommend some contraceptive methods over others?"

Developing Indicative Questions

Questions that were in scope and covered similar areas were grouped and re-framed as summary questions. For example:

HCP	If there are any patient characteristics to predict the bleeding pattern of progestogen-only contraception
Patient	I don't tolerate progesterone only contraception e.g. mini pill, injection, implant – what is it in these that causes me to constanly bleed?
HCP	Why do some people experience irregular bleeding on all methods of contraception (exc. Cu-IUD?) What is the mechanism and is there an alternative apart from Cu-IUD?
HCP	Why do women of African/Caribbean origin have different bleeding profiles with hormone based contraception?
HCP	Is there a way to predict bleeding patterns for particular women or to extrapolate from previously-used contraception?

Searches were carried out to see if these questions had already been answered by high-quality evidence. We used the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) approach to assessing the quality of the evidence used. High-quality evidence usually comes from a systematic review of randomised control trials, but may also come from well-conducted observational research. In either, the risk of bias is low, and there we can be very confident that the true effect lies close to the effect estimated in those studies. It is unlikely that further research will change this.

The search included:

1. Searching for evidence-based guidelines: on websites of national organisations, professional societies and guidelines databases.
2. Systematic reviews: Cochrane library was searched for relevant systematic reviews and randomised control trials. The database PROSPERO was searched for registered systematic reviews in progress.
3. Turning Research Into Practice (TRIP) and PubMed databases were also searched for evidence-based guidelines and systematic reviews.

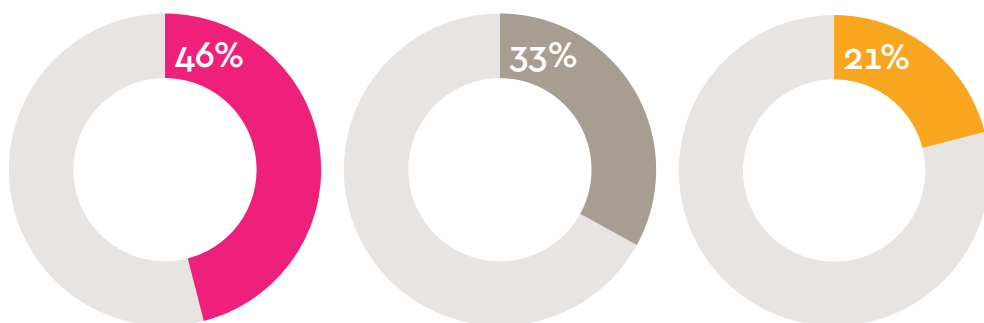
Members of the Steering Group then went on to discuss 'borderline' questions, assessing whether these questions were supported by sufficient evidence to consider them 'answered' or 'unanswered'. This process gave rise to 57 unanswered research questions to be ranked and prioritised (Appendix 2).

Are there factors (ethnicity, past experience) that can predict who is at risk from irregular bleeding when using hormonal contraception?

Stage 4: Interim Prioritisation

Second survey

With a second survey, service users and healthcare professionals were asked to prioritise the 57 questions according to their importance for research. This process resulted in a shortlist of 29 questions (Appendix 2) that was taken to the final Contraception PSP workshop. A total of 407 people took part in the second survey: 46% of respondents used or had thought about using contraceptive care (or their partner had); 21% were healthcare professionals working in the area of contraceptive care and 33% fell into both categories.



Total respondents = 407

- Used or had thought about using contraceptive care (or their partner had)
- Both
- Healthcare professionals working in contraceptive care

Generating the final shortlist

Survey submissions were divided into groups according to respondent type; service user, healthcare professional or both. Each ranked question was then given a score from 1–10 whereby a question ranked as number 1 received 10 points and a question ranked in 10th place was given 1 point.

To ensure equal weighting for each respondent type, points for each of the 57 questions were added together and summed separately for each respondent category. Within each respondent type, the totals for each question were ordered from highest to lowest and given a new score according to their position, from 57 for the most popular question to 1 for the least popular. Questions with the same total were ranked in joint place and given an average score between them. The scores for each question, based on its position within each respondent type, were then added together, resulting in a combined ranked list of shared priorities from 1–57.

JLA recommends 20 to 30 questions as a manageable number for the final workshop. The Steering Group reviewed the full ranked list and agreed a maximum of 29 questions. Importantly, this ensured that the 'Top 10' questions from each of the three respondent groups were included in the final shortlist.

Stage 5: Final Prioritisation Workshop

On 21st April 2017, the final Contraception PSP workshop was held at the RCOG in London.

Participants

Twelve service users and the same number of healthcare professionals were invited to participate in a day of group discussions facilitated by JLA Advisers in order to reduce the short list of 29 questions to the final 'Top 10' research priorities for contraceptive care. Service users across the reproductive life-course were invited to attend, including men, pregnant women and those who had already had children.

Likewise, healthcare professionals from across the breadth of care settings in which contraceptive care is delivered were invited to participate. These included midwifery, specialist contraception services, general practice, practice nursing, community pharmacy and obstetrics and gynaecology. One man took part in the final workshop.

How were the 'Top 10' decided on the day?

The workshop process on the day followed the standard JLA priority setting approach which draws on Nominal Group Technique. This involves a series of small and large group discussions and ranking

exercises facilitated by JLA Advisers. Participants received the short list in a random order ahead of the day and were asked to prepare their own rankings to discuss with the group. Each of the 29 questions were printed on A4 cards, with one set of cards allocated to each small group to work with, and the interim priority setting results printed on the back of each card.

1

Workshop phase 1:
small group discussions

Three separate groups of healthcare professionals and service users shared their views on the questions they felt were the most and least important.

Using the printed question cards, the same three groups ranked the 29 uncertainties in priority order.

Workshop phase 2:
first round of small group ranking

2

3

Workshop phase 3:
whole group review

Each group's ranking was entered into an Excel spreadsheet, and a first aggregate ranked list was achieved. The JLA Adviser chairing the meeting presented an overview of the results and gave participants the opportunity to raise any questions, comments and concerns for discussion with the whole group.

Participants were then divided into three new groups – again with an equal balance of service users and healthcare professionals – to discuss and revise the combined ranked list. In these groups, participants continued to discuss and rank all 29 questions, working with the cards, but were encouraged to focus on the top 15.

Workshop phase 4:
second round of small group ranking

4

5

Workshop phase 5:
final whole group review

The small group scores were again recorded in the Excel spreadsheet, and the aggregate ranking was presented to the whole group, by laying the cards out on the floor. The whole group then had an opportunity to comment on and suggest final changes to the ordering of the questions. Where a decision could not be made by discussion, a vote took place. After a detailed discussion, facilitated by the JLA, the final 'Top 10' was agreed.

'Top 10' Research Priorities for Contraceptive Care

1

Which interventions (decision support aids, ease of access, motivational interviewing) increase uptake and continuation of effective contraception including long-acting methods (implants, injections and intrauterine contraceptives)?

2

What is the risk of side effects (vaginal bleeding, mood, weight gain, libido) with hormonal contraception (pills, patches, rings, implants, injections and hormonal intrauterine system)?

3

What are the long-term effects of using contraception (pills, patches, rings, injections, implants, intrauterine) on fertility, cancer and miscarriage?

4

What models of care increase access and support decision-making for vulnerable groups (such as young people, people who don't speak or read English)?

5

Which interventions are safe and effective for women who have irregular bleeding on long-acting hormonal contraception?

6

Does pharmacy provision of contraceptive services increase uptake and/or continuation of contraception?

7

What are the risks or benefits to using combined hormonal contraception (pill, patch or ring) continuously to stop or reduce periods?

8

What factors (advice from friends, family, professionals, beliefs, experience) influence women making decisions about contraception?

9

Are there tests or factors such as age that can reliably identify women who no longer require contraception around the menopause (including women using methods which can stop periods such as implants, hormonal coils, pills)?

10

Are there effective new methods of contraception available for men?

Launch of the 'Top 10'

The agreed 'Top 10' unanswered research priorities for contraceptive care were announced on 27 April 2017 at FSRH's Annual Scientific Meeting (ASM) in Cardiff, Wales, where healthcare professionals from across contraceptive care met to discuss the most recent scientific and research developments in the field.

What happens next?

The PSP is working with the National Institute for Health Research Evaluation, Trials and Studies Coordinating Centre (NETSCC) and other research funders to develop the priorities into research questions that might be commissioned and monitor the impact of the priority setting process.

We need you!

To maximise the impact of the 'Top 10' research priorities and reach as many stakeholders as possible, please share this report among your networks and across your social media platforms.

Please use the hashtag [#ContraceptionTop10](#) and tag [@FSRH_UK](#). You can also contact us at info@fsrh.org.



Appendix 1 – Posters used to promote initial Contraception PSP Survey

FSRH

James Lind Alliance
Priority Setting Partnerships

Do you want to help shape the future of contraception research?

The Contraception Priority Setting Partnership (PSP), a group of health care professionals and patient representatives, are working together to find out the 'Top 10' contraception research priorities.

Whether you're a patient or clinician, male or female, we want to hear your unanswered contraception questions. Scan below to take part in our survey or visit www.ContraceptionPSP.com/survey

To find out more about us visit www.ContraceptionPSP.com

The Contraception PSP is working in partnership with the following organisations:
The Palatine Centre Manchester, Brook, Primary Care Women's Health Forum, FPA, Royal College of Obstetricians and Gynaecologists, Marie Stopes UK, BPAS, Institute of Health Visiting.



FSRH

James Lind Alliance
Priority Setting Partnerships

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Appendix 2 – Social media campaign images

FSRH The heart of SRH
James Lind Alliance
Priority Setting Partnerships
Top 10 research priorities in contraception
#ContraceptionTop10 @FSRH_UK

1 Which interventions increase uptake and continuation of effective contraception including long-acting methods (implants, injections and intrauterine contraceptives)?

FSRH The heart of SRH
James Lind Alliance
Priority Setting Partnerships
Top 10 research priorities in contraception
#ContraceptionTop10 @FSRH_UK

2 What is the risk of side effects with hormonal contraception (pills, patches, rings, implants, injections and hormonal intrauterine system)?

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James Lind Alliance
Priority Setting Partnerships
Top 10 research priorities in contraception
#ContraceptionTop10 @FSRH_UK

3 What are the long-term effects of using contraception on fertility, cancer and miscarriage?

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James Lind Alliance
Priority Setting Partnerships
Top 10 research priorities in contraception
#ContraceptionTop10 @FSRH_UK

4 What models of care increase access and support decision-making for vulnerable groups?

FSRH The heart of SRH
James Lind Alliance
Priority Setting Partnerships
Top 10 research priorities in contraception
#ContraceptionTop10 @FSRH_UK

5 Which interventions are safe and effective for women who have irregular bleeding on long-acting hormonal contraception?

FSRH The heart of SRH
James Lind Alliance
Priority Setting Partnerships
Top 10 research priorities in contraception
#ContraceptionTop10 @FSRH_UK

What are the questions that women and healthcare professionals want contraception research to answer?

Collaboration, Choice, Care: the Contraception Priority Setting Partnership (PSP) top 10 research priorities in contraception

Appendix 3 – Long list of verified unanswered research questions for contraceptive care

Below is the full ranked list of 57 verified unanswered research questions for contraceptive care generated by the initial Contraception PSP Survey.

The first 29 are ranked in priority order by participants at the final Contraception PSP workshop. The remaining questions are in the order ranked by the interim priority setting survey.

1. Which interventions (decision support aids, ease of access, motivational interviewing) increase uptake and continuation of effective contraception including long-acting methods (implants, injections and intrauterine contraceptives)?
2. What is the risk of side effects (vaginal bleeding, mood, weight gain, libido) with hormonal contraception (pills, patches, rings, implants, injections and hormonal intrauterine system)?
3. What are the long term effects of using contraception (pills, patches, rings, injections, implants, intrauterine) on fertility, cancer and miscarriage?
4. What models of care increase access and support decision-making for vulnerable groups (such as young people, people who don't speak or read English)?
5. Which interventions are safe and effective for women who have irregular bleeding on long-acting hormonal contraception?
6. Does pharmacy provision of contraceptive services increase uptake and/or continuation of contraception?
7. What are the risks or benefits to using combined hormonal contraception (pill, patch or ring) continuously to stop or reduce periods?
8. What factors (advice from friends, family, professionals, beliefs, experience) influence women making decisions about contraception?
9. Are there tests or factors such as age that can reliably identify women who no longer require contraception around the menopause (including women using methods which can stop periods such as implants, hormonal coils, pills)?
10. Are there effective new methods of hormonal contraception available for men?
11. What are the most effective methods of promoting sexual health services (to everyone, including young people, those who don't speak or read English or who are vulnerable)?
12. What are the benefits and risks of using micronised progestogen or newer progestogens (such as Nomegestrol acetate, drospirenone) either in pill form or in long acting preparations, such as implants, or in combined hormonal contraception?
13. If the progestogen-only pill was available over the counter would this be acceptable and safe?
14. What is the risk of stroke for women suffering from migraines who are using combined hormonal contraception (pill, patch, ring)?
15. Are there health risks for women who take emergency contraception repeatedly?
16. Do progestogens used alone or in combined hormonal contraception interact with anti-depressants?

17. Are there factors (ethnicity, past experience) that can predict who is at risk of irregular bleeding when using hormonal contraception (progestogen only or combined)?
 18. Does providing women who are pregnant with information about contraceptive services and choices increase the uptake of contraception after childbirth?
 19. Do models of care (video information, telephone assessments, single appointments) increase access to intrauterine contraceptives and implants?
 20. How effective are 'natural family planning methods' (monitoring menstrual cycle, basal body temperature, cervical mucus), and do fertility apps and/or urine testing improve this?
 21. Are intrauterine contraceptives (IUC) affected if not correctly positioned (eg if low lying, embedded in or dislodged from the uterus)?
 22. What are the health risks (osteoporosis, bone fracture) of using contraceptive injections, and do these increase with duration of use or vary with age of use?
 23. Does ovulation, menstrual cycles and fertility return to normal immediately after contraception is stopped?
 24. How frequently do women stop using the implant because of side effects?
 25. How common is it for side effects (mood/weight gain/loss of libido) to occur in women who are using combined hormonal contraception (pill, patch or ring)?
 26. What methods of pain relief are effective during intrauterine contraceptive insertion (oral analgesia, local anaesthetic gel, spray or injection)?
 27. Why aren't there progestogen only transdermal patches, gels, vaginal rings or combined injections available for use as contraception?
 28. Why don't more young women choose to use intrauterine contraception (is this influenced by friends, family, professionals, access to services)?
 29. What risk factors are there for deep insertion of implants?
 30. What is the risk of side effects with a copper intrauterine device (CU IUD) in all women, teenagers and women who haven't had children?
 31. Does the point in a menstrual cycle when a hormonal intrauterine device (IUS) is fitted influence the risk and duration of irregular bleeding women experience?
 32. Is the effectiveness (including absorption) of progestogen injections reduced in women who are overweight?
 33. Does the size of a woman's uterus impact on the effectiveness of intrauterine contraception (hormonal intrauterine systems (IUS) and copper intrauterine devices (IUD)?
 - =34. How effective is breastfeeding as contraception?
 - =34. Which interventions, including variable pill-free interval, reduce the risk of pregnancy for women using the combined hormonal contraception?
 36. What are the benefits and risks of different contraceptive methods for women who are breastfeeding?
 37. How effective are condoms/how often do condoms split?
 38. Following childbirth, when is it safe to have intrauterine devices (copper and hormonal) fitted?
 - =39. In women using combined hormonal contraception (pill, patch, ring) how should breakthrough bleeding be managed?
 - =39. What are the risks and benefits of different contraceptive methods for women with diabetes (type 1 and 2)?
 - =41. Does the progestogen only pill or other hormonal contraception help with pre-menstrual syndrome?
 - =41. What are the risks or benefits to using combined hormonal contraception (pill, patch or ring) compared to the progestogen only pill?
- = denotes equal ranking

43. What is the risk of pregnancy when using the withdrawal method or having unprotected vaginal sex without using contraception?
44. How do the risks and benefits of different contraceptive methods differ for women with HIV?
- =45. Do patient reminders for expiry of long acting contraceptive methods reduce contraceptive failures?
- =45. How can women access reliable information (online, apps) or services that help women to use natural family planning methods?
47. What is the risk of pregnancy after 'quick starting' contraception?
48. What are the risks to fitting intrauterine contraception in women after they have had endometrial ablation (a surgical procedure to reduce the lining of the womb)?
49. Are there interventions that can reduce side effects of the contraceptive injection?
50. Are intrauterine devices acceptable as emergency contraception for young women?
51. What are the risks or benefits of the hormonal intrauterine contraceptive (IUS) in women with submucosal fibroids?
52. What are the risks associated with hormonal contraceptives among women who have SLE (systemic lupus erythematosus) with or without antiphospholipid antibodies?
53. Are women switching from a long acting method to a pill at greater risk of contraceptive failure and/or an unplanned pregnancy?
54. Has the change in guidelines regarding insertion of intrauterine contraception at the time of caesarean section increased the use of this method?
55. What are the risks associated with hormonal contraceptives among women who have had obstetric cholestasis (a rare complication of pregnancy which causes severe itching in the last three months of pregnancy)?
56. Does giving oral emergency contraception reduce attendance for fitting intrauterine devices as emergency contraception?
57. How effective is the progestogen only pill (POP)?

References

¹ For more information on the James Lind Alliance (JLA) please visit:

www.jla.nihr.ac.uk

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Collaboration, Choice, Care:
The Contraception Priority
Setting Partnership (PSP)
www.contraceptionpsp.com
www.fsrh.org
www.jla.nihr.ac.uk