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SHORT COMMUNICATION

Who is responsible for postpartum contraception advice and provision? The perspective of hospital-based maternity clinicians in New South Wales, Australia

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Access to postpartum contraception is critical for the health of the mother and subsequent pregnancies. However, the differential roles and responsibilities of maternity care providers in contraception discussions and provision are often unclear. Our study, part of a larger study on midwifery provision of contraceptive implants, presents the perspectives of hospital-based maternity clinicians. Participants suggested that contraception discussions and provision are a shared responsibility of maternity care providers but identified inconsistencies and issues with current approaches. Access to contraception could be improved through more routine discussions antenatally and postnatally and greater collaboration between maternity care providers in hospital, community and primary care settings.

KEYWORDS

access, clinician, maternity care provider, midwife, postpartum contraception

INTRODUCTION

Many pregnancies in the first year after a birth are not intended,[1,2] leading to short inter-pregnancy intervals (<24 months) and potential perinatal complications.[3–5] Although postnatal women commonly rely on lactational amenorrhoea for contraception, many are not advised or aware that this method is only effective when exclusively breastfeeding, when amenorrhoeic and when less than six months postpartum.[6] Further, only about 60% of Australian infants are exclusively breastfed for at least four months and fewer among single-parent families and those living in low-socioeconomic areas.[7] As ovulation as well as sexual activity may resume within weeks of a birth,[8] early access to postpartum contraception is critical to prevent unintended pregnancies and to facilitate subsequent pregnancy planning (if desired).[3,9]

Postpartum contraception can be accessed in several ways in Australia, including in hospital immediately after birth

or with a general practitioner (GP) or private obstetrician. However, a number of barriers to this access exist.[10,11] There is no consistent policy nor guidelines in Australia[11] to ensure timely access to postpartum contraception information and services, and the role of maternity care providers in postpartum contraception provision, including midwives, obstetricians and GPs, is highly variable.[12–15] In contrast, in the UK and the USA there are clear guidelines recommending that clinicians caring for pregnant women should be involved in postpartum contraception care.[8,16]

As part of a larger body of work exploring midwifery provision of contraceptive implants in New South Wales, Australia, we interviewed hospital-based maternity clinicians about women's access to postpartum contraception and the role of maternity care providers in contraception discussions and provision.

MATERIALS AND METHODS

This paper reports findings from interview data collected from hospital-based maternity clinicians as part of a larger body of work investigating the feasibility, acceptability and sustainability of postpartum contraceptive implant insertions by midwives. Methods are described in detail in a separate paper.[17] Ethics approval was received from the Sydney Local Health District RPAH (approval no.: X18-0314) and Family Planning NSW (approval no.: R2018-05) Human Research Ethics Committees.

The study was conducted in a large tertiary referral hospital and a smaller metropolitan hospital in New South Wales from 2019 to 2021 and involved the upskilling of midwives in insertion of the contraceptive implant.[17] Towards the end of the study, hospital-based maternity clinicians, including all participating midwives and purposively identified doctors and managers, were invited to participate in a semi-structured interview to explore their experiences of the study and views regarding postpartum contraception. (Pharmacists were also interviewed; however, they were excluded from this particular analysis.) This paper presents the views of interview participants on women's access to postpartum contraception and the role of maternity care providers.

After verbal consent, interviews were audio-recorded and transcribed verbatim, quality checked, de-identified and coded using NVivo software.[18] Author one undertook line-by-line coding of all transcripts, while author two coded a selection of transcripts to strengthen the quality and rigour of analysis. The principles of reflexive thematic analysis[19,20] were followed to identify and analyse data relating to midwifery provision of the contraceptive implant (findings published separately[17]). Through this process, findings relating to postpartum contraception access more generally were evident. Thematic analysis of data codes pertaining to access, contraceptive discussions and the role of maternity care providers was undertaken by author one, in consultation with the broader research team.

RESULTS

Interviews were conducted with 21 hospital-based maternity clinicians (13 midwives, three doctors (staff specialists and residents), four midwifery managers and one clinical midwifery specialist). All participants discussed the importance of access to postpartum contraception and shared views relating to contraception discussions and the role of maternity care providers. Table 1 provides a summary of key quotes from interviews.

Participants suggested that education and information on postpartum contraception should be part of routine maternity care. This should ideally start antenatally to support women in considering options, allow time for ongoing discussions with health providers and others and assist them to 'make a plan' and facilitate timely access to a contraceptive method of their choice. However, many participants identified inconsistencies and issues with current approaches to provision of postpartum contraception information and services in maternity care in New South Wales. Experiences and anecdotes among participants varied, with suggestions that contraception may be discussed in detail, only briefly or not at all antenatally or during women's hospital stay. Provision of postpartum contraception was also highly variable. The limitations of these varied approaches and the subsequent 'unmet need' were highlighted, including that most women are discharged from hospital with no contraception or consideration of options and the timing of GP appointments, and prioritisation of contraception at these appointments is variable.

All participants emphasised the important role of midwives in providing contraception information. However, there was also recognition that all maternity care providers have a role in working collaboratively and supporting women throughout their pregnancy to consider their contraception options and facilitate their access to postpartum contraception.

Ensuring that postpartum contraception was accessible in hospital, primary care and community settings was raised across interviews. Participants stated that women vary in their preferences for contraception, with some preferring to access contraception in hospital, others from their GP or elsewhere and some who are unsure or not aware of their options. Many participants felt that hospital provision of postpartum contraception could facilitate access, particularly for those without a GP or who may be less likely to follow up with a GP. Utilising community-based midwives or nurses in discussing and providing postpartum contraception was also suggested.

DISCUSSION

Findings from our study suggest that hospital-based maternity clinicians view provision of contraception information and services as a shared responsibility between hospital and community maternity care providers. However, although maternity

TABLE 1 Quotes from participant interviews

Early contraceptive discussions and planning	'So usually the point of (my contraception conversations is to say) here's options, it's important to talk to your partner and have a plan, and the way you can go about making that plan is, like, learn the information and then talk to your midwife or your GP about actually undertaking the plan' (M02, midwife) 'I do feel that women are actually very open to the idea – to talk about (contraception) antenatally and they like the idea they can go home, research it, come back' (S07, doctor) 'I think that those discussions need to commence in late pregnancy, and then they are ongoing' (S10, midwifery manager) 'Women always need time to process the information and think about it, so it's always going to need multiple discussions. And if you have had one or two discussions, antenatally, yeah, you are going to have a much better idea, postnatally of what you want. And I also think, antenatally is the best time because you are not sleep deprived and trying to care for a newborn baby and transition to motherhood. I mean, how do you make decisions when all that's happening?' (M12, midwife) 'Well, most women are really interested in hearing about their choices and their options, and mostly want to do their own research before making a decision' (M08, midwife)
Inconsistencies and issues with current approaches	'Generally it would be a discussion around what methods had they used before, had they thought about how to plan their pregnancies … usually the end of the conversation was, talk to your postnatal midwife about it, and talk to your GP about it' (M02, midwife) 'I think more and more a lot of midwives do always try to work (contraception) in to conversation. But, obviously, if you are rushed off your feet you always have to prioritise, and if you have a lot of emergencies and really complicated medical issues going on in a day, those discussions fall by the wayside, they fall down the priority list and on busy days, often, you do find yourself just saying to the woman, discuss contraception with your GP in six weeks' (M12, midwife) 'Our average stay [in hospital] is two days now, so, with that, you really hope that they go to the GP if they do decide that they want (contraception)' (M13, midwife) 'The barriers build on each other … the partner would need to go get (the contraceptive implant or (IUD)), buy it, bring it back before they discharge. They'd then need to find someone who can insert it … [and] most women here discharge within 24 to 48 hours of birth' (M12, midwife) 'Even for the grandmultips I do not think we cover contraception very well antenatally … (and they) did not want to talk about it on day one (postpartum) because they were tired and they just wanted to get home … but on day seven they are almost desperate for one but they do not want to come back in so that's an unmet need and then relying on that woman to then go to the GP at six weeks, that's just flawed' (S09, midwifery manager)
Role of maternity care providers	'I am aware that (my colleagues) do not talk about contraception as much as I do. So it's like, I feel responsibility to bring it up with every woman who crosses my path to ensure that at least they know that there's options because other people aren't bringing it up' (M03, midwife) '(Midwives) have that opportunity to be with women throughout the antenatal and post-natal period.... I think that we have an integral role, and in bringing it up as well. I mean even if it's not locked in and actioned; bringing it up, providing the information … and talking about the different places they can go' (M04, midwife) 'It is the midwife's role. Even if it's just the midwife's role to start having those conversations so planting the seed so to speak for women to then have access to ongoing family planning and that may not be midwifery-based, as obviously we have family planning nurses and midwives who are out in the community. But women need to know how to access them' (S10, midwifery manager) 'I think it's the person, the primary carer who's taking care of her [who is best placed for contraception discussions]. So whether it be the doctors or the midwives, whoever, or even the GP … they are the ones who are seeing her throughout her pregnancy as well as postpartum' (S07, doctor) 'It's all about choice and not making it too hard. You're sending someone home with five kids and then expecting them to make it back to a family planning clinic. And it can be really difficult. So if they can make the decision while they are here [in hospital].... And then if they have any issues, of course they can see their GP or let us know. But it's just to give them the choice and just make it easier for them' (M09, midwife)

TABLE 1 (Continued)

Consideration of hospital, primary care and community settings	'I think coming into a maternity system it's such a good opportunity to offer (family planning services). But often we do just focus on the baby, basically. Once the baby's out, the woman's broader reproductive health suddenly becomes less important again. And also in her life, often for a lot of the women here, having a baby is the only time they'll really engage with the health system. And so I think it's such an opportunity to offer those services' (M12, midwife) '[Midwives working in continuity of care models] have those two weeks where you have that opportunity to talk to women (postnatally).... I feel like it is something doable, that women should be offered (contraception information).... It is part of our role that we should finish it properly' (M08, midwife) 'The question I really ask is how can we, if ever, make it something that could do at home ... once they have left the hospital there's no longer a live encounter; it's just not that streamlined. Is there a community nurse functionality within midwifery ... that's something I think the midwifery at home midwives would be really in favour of ... the ones that are really having the meaningful conversations are I think the midwives at home.... I think if we were to target education that's where it would be because our length of stay [in hospital] is so short, women are really not thinking that far ahead' (S09, midwifery manager) 'A number of women I've started (the contraception) chat with them while they have still been in-patients. They've then been discharged but followed up by Midwifery at Home. And then they have chosen to come back a few days after it's all sunk in and they have decided. And we have done a midwifery home visit on the ward and I've inserted (the contraceptive implant) then' (M12, midwife)

care providers such as midwives, obstetricians and GPs are ideally placed to discuss and provide contraception antenatally and postnatally, there appears to be neither a consistent nor coordinated approach to postpartum contraceptive counselling or provision within services in New South Wales, nor processes for following up women and ensuring they can access contraception in a timely manner. There is therefore a need for more clearly defined roles and responsibilities in relation to postpartum contraception care, supported by the creation of opportunities for shared learning and good communication and collaboration between care providers and across settings.

International guidelines[8,16] recommend provision of postpartum contraception information and services be integrated into maternity care pathways and led and prioritised by primary maternity care provider(s) who provide antenatal, intrapartum and postpartum services. Our study findings align with these recommendations. Early, regular and routine provision of contraception information may facilitate decision-making before or immediately after birth, which may reduce some of the logistical barriers to accessing postpartum contraception. For many women in New South Wales, their primary maternity care providers are midwives, as well as GPs involved in shared care and child and family health nurses who provide baby health checks and parenting support. Given the range of health professionals working in maternity care provision in Australia, consideration of midwifery- and nurse-led models of contraceptive care and innovative models of service provision in home and community settings may help to facilitate decision-making and access. Importantly, a collaborative approach between maternity care providers in hospital, community and primary care settings in discussing and facilitating access to postpartum contraception is required to support the transition between care services and providers. Care coordination and communication pathways are in line with New South Wales government policy aims, and the development and strengthening of referral pathways between hospital maternity services and GPs is a state government priority.[21]

These findings are based on an analysis of interview data exploring postpartum contraceptive implant insertions by midwives. Although issues of postpartum contraception access were raised, this was not the primary focus of interviews. Importantly, this paper reports only the views of hospital-based maternity clinicians; further exploration of the perspectives of childbearing women, community midwives and nurses, GPs and general practice nurses is warranted. The impact of faith-based hospitals on access to postpartum contraception information and services would also be important to explore in Australia.

CONCLUSION

Postpartum contraception discussions and provision are regarded as important by hospital-based maternity clinicians and as a responsibility to be shared by maternity care providers. Such care would ideally be led by the primary maternity care provider. Currently these services are not routinely available nor always easily accessible in Australian maternity care settings, compounded by a lack of a consistent approach to postpartum contraception management. Access to postpartum contraception could be improved through routine inclusion of contraception discussions during antenatal and postpartum care and shared learning and greater collaboration between maternity care providers. This would ideally occur across hospital, community and primary care settings to support continuity of care through the postpartum period.

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