

Midwives' experiences and views of giving postpartum contraceptive advice and providing long-acting reversible contraception: a qualitative study

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Received 23 August 2013

Revised 12 December 2013

Accepted 17 December 2013

Published Online First

5 February 2014

ABSTRACT

Background National sexual health frameworks in the UK advise that women in maternity units who are at risk of unintended pregnancy should receive contraceptive advice and supplies of the most effective long-acting reversible methods of contraception (LARC). In the UK, midwives currently deliver contraceptive advice to women following childbirth. There is a lack of information on how midwives currently view their role as provider of contraceptive advice and how they would feel about expanding this to include provision of LARC.

Objective To explore midwives' experiences and views of giving postpartum contraceptive advice and of possible expansion of role to include provision of LARC.

Methods Semi-structured, audio-recorded interviews were carried out with 12 midwives involved in the postpartum care of women in Edinburgh, Scotland, UK. Interviews were transcribed verbatim and analysed using thematic analysis.

Results Midwives confirmed that they all routinely give contraceptive advice but that this was mostly cursory. They viewed this part of their job as of lesser importance and one that they felt inadequately trained for. Many barriers to discussing contraception were identified including lack of time and privacy, or mothers being preoccupied with concerns about their baby. Midwives expressed concern about taking on a greater role in giving contraceptive advice or providing LARC, given their current heavy workload.

Conclusions Midwives require ongoing training and support to be effective in their current role as provider of contraceptive advice. Better links between midwifery and specialist sexual and reproductive health services should therefore be

Key message points

- ▶ High-quality postpartum contraceptive advice and provision of the most effective methods is considered important in reducing unintended pregnancies.
- ▶ Midwives are providers of postpartum contraceptive advice but most feel inadequately equipped to provide more than basic advice.
- ▶ Training and support from sexual and reproductive health services is important if maternity services are to be effective in providing quality postpartum contraceptive services.

encouraged, particularly if a midwife's role is expanded to include provision of contraception such as LARC.

INTRODUCTION

Guidelines from the National Institute for Health and Care Excellence advise that methods of contraception should be discussed within the first week of birth.¹ Currently in the UK, mothers are asked about their contraceptive intention by a midwife prior to discharge from the maternity unit. Women may also have the opportunity to discuss contraception (and receive supplies) if they attend a 6 weeks postpartum check with their general practitioner (GP).² Women who wish to use a long-acting reversible method of contraception (LARC) such as an intrauterine method (intrauterine device/system) or implant may be advised that they should



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To cite: McCance K, Cameron S. *J Fam Plann Reprod Health Care* 2014;**40**:177–183.

make a further appointment either with their GP or with a specialist sexual and reproductive health (SRH) service. This need for multiple appointments for postpartum contraception leaves women open to the risk of unintended pregnancy. Research from Scotland suggested that over one-third of births were not intended at conception.³ Unintended childbearing is associated with poor-quality relationships between the mother and child⁴ and adverse effects upon mental health.⁵ Likewise, short inter-pregnancy intervals (of under 1 year) increase the risk of preterm delivery and neonatal death.⁶ There is growing recognition in the UK that women's need for effective contraception in the 'immediate' postpartum period has been largely underestimated. There is good evidence that almost 50% of women have resumed sex by 6 weeks postpartum.⁷ Ovulation can resume as early as Day 28 in a woman who is not breastfeeding⁸ and whilst it is true that women who are exclusively breastfeeding may rely on this for contraception, data show that only 26% of Scottish mothers are exclusively breastfeeding at 6 weeks, and that the figure is only 5.5% for mothers under 20 years of age.⁹ So clearly a large proportion of the postnatal population are potentially at risk of another pregnancy soon after delivery. This strengthens the case for providing high-quality contraceptive advice to mothers postpartum and for the provision of the most effective contraception at this time.

Research from our maternity service in Lothian, Scotland over 16 years ago, showed that postnatal discussion about contraception was often cursory, that obstetricians had little interest in contraception, and that the discussion was usually with the midwife.¹⁰ More recent evidence suggests that contraceptive advice given to mothers in the UK continues to be of poor quality, since a nationwide survey of mothers reported that women were highly dissatisfied with the current provision of postnatal contraception.¹¹ Currently there is a lack of data from UK health care providers about their views on provision of postpartum contraception.

The Royal Infirmary of Edinburgh (RIE) is the main maternity unit in National Health Service (NHS) Lothian (Edinburgh and region), Scotland, responsible for delivering over 6000 births per year.¹² In 2011 the Scottish government outlined the importance of mothers receiving contraceptive advice with emphasis on effective LARC methods.¹³ Given the lack of existing data from UK midwives regarding their role in giving postpartum contraceptive advice, we wished to determine the views and experiences of midwives providing that advice to women delivering in the maternity services of the RIE in 2013.

METHODS

Sampling

A purposive sample of 12 midwives involved in postpartum care of women in Edinburgh, Scotland was

recruited. Three groups were recruited: midwives working in the birth centre (a midwife-run, low-risk delivery suite) at the RIE, the postnatal wards at the RIE, and community midwives. Midwives at RIE were approached directly by the researcher and received verbal and written information about the study. Community midwives were sent an information sheet about the study by a senior ward midwife and asked to contact the researcher by e-mail if they were willing to participate. All participants gave written informed consent.

Data collection

Data was obtained by individual semi-structured interviews that lasted about an hour. Interviews were conducted during February and March 2013. A topic guide, based on the research questions, outlined the key areas to be covered in the interviews. These were conducted either in the 'quiet room' on the postnatal wards, in a vacant delivery room in the birth centre, or in the midwives' home or medical practice (community midwives). Interviews were audio-recorded and transcribed verbatim.

Analysis

Data were organised by cross-sectional indexing and an inductive approach was adopted. New ideas that arose in the initial interviews were explored in subsequent interviews and the topic guide altered to facilitate this (Table 1). After all the interviews were completed, the data were analysed using thematic analysis. This involved six phases based on those outlined by Braun and Clarke¹⁴ and included familiarisation with the data set by repeatedly reading transcripts, generating codes for emerging themes and defining and naming themes. South East Scotland Research Ethics service reviewed the proposal and confirmed that no ethical review was required. NHS Lothian Research and Development team approved the project and clinical governance approval was obtained from the NHS Lothian quality improvement team for sexual health.

RESULTS

Twelve midwives were interviewed: two community midwives, four midwives working in the birth centre and six midwives working on the postnatal wards. Their experience levels ranged from being qualified for just over 1 year to being qualified for 32 years.

Current role of midwives in giving contraceptive advice

When is contraception discussed?

All midwives discussed contraception with women and this was done routinely as part of a checklist when discharging women from their care. The community midwives stated that they also discussed contraception antenatally in certain circumstances,

Table 1 Summary of main areas covered during interviews

Topic	Areas covered
Role as provider of contraceptive advice	Importance of this part of job Importance of advice given How midwives go about giving advice Aspects of contraception discussed LARC included in contraceptive discussion? Contraceptive plan made? Duration of contraceptive discussion Role of midwife to give advice? And/or other health care professionals?
Timing of advice	Best time to give contraceptive advice? Views on antenatal versus postpartum Contraceptive advice at 6-week GP check Contraceptive needs in first 6 weeks postpartum
Target groups	Particular groups of women that it is harder to give contraceptive advice to? Particular groups of women who should be targeted with contraceptive advice more than others?
Training	Current contraception knowledge levels sufficient? Contraceptive training to date Facilitators and barriers to giving contraceptive advice
Providing LARC	Current provision of contraceptive supplies and LARC? Process barriers to providing contraceptive supplies Feelings about being trained to insert LARC methods (e.g. implants)

GP, general practitioner; LARC, long-acting reversible contraception.

such as women who had a history of unintended pregnancies, or those considering sterilisation at Caesarean section.

What is covered in the discussion?

Although all groups of midwives discussed contraception, there were wide variations in the scope and depth of discussion. Postpartum return of fertility and the unreliability of breastfeeding as a contraceptive were consistently covered. They informed women about where they could access further contraceptive advice and contraceptive supplies. Some midwives discussed the range of contraceptive methods available if women wished to, but others did not do so. No midwives made a firm contraceptive plan with women, the only plan being that they should see another health care professional to obtain further advice and supplies.

A minor role

Midwives generally thought discussing contraception was a minor part of their job and that the influence they exerted on a woman's choice of contraception was minimal (Box 1). They generally perceived that the main aim of the discussion was to dispel myths about return of fertility and to emphasise the unreliability of breastfeeding as a contraceptive. Indeed, when midwives were informed about the topic of the research project (postpartum contraception) there was general surprise that it was on contraception. One midwife said "we don't really deal with that".

When and who should be giving postpartum contraceptive advice?

Midwives had clear but often differing views of when and who should give mothers contraceptive advice.

It was generally thought that antenatal discussion would not benefit the majority of women as it was felt that women are so preoccupied with the fact they are having a baby that are unlikely to be interested in, or to consider, contraception options following childbirth (Box 2). Some midwives thought that for certain groups of women, such as for teenage mothers, raising the subject of contraception antenatally might be useful. In general, the hospital midwives considered that other health professionals such as social workers, community midwives, GPs or obstetricians were all better placed than they were to have the discussion about ongoing contraception.

Most thought that in-depth discussion on the subject whilst in hospital was inappropriate. One community midwife suggested it should not be brought up in hospital at all: "It's not really a priority ... contraceptives can wait". The majority of midwives considered contraceptive discussion with the community midwife at Day 10 to be more appropriate than at discharge from hospital (Box 2).

Contraceptive discussion with the GP at the 6-week postnatal visit was thought to be good because by then women are "more settled and getting back to normal". Conversely, concerns were raised that GPs might not address postnatal contraception at the 6-week postnatal visit or that GPs may not be up to date with current contraceptive methods. It was also

Box 1 Quotes from midwives expressing how they view their role in discussing contraception

"Just say, see your GP in six weeks time and be safe."
[Postnatal ward]

"I don't think that I need to discuss it in depth with them when they are at the stage that I discharge them into the community." [Birth centre]

"I give very basic information at the time I discharge but very very basic." [Postnatal ward]

Box 2 Quotes from midwives expressing various views on the timing of postpartum contraceptive advice and who should be providing this advice

"I don't think many women would be very receptive to discussing contraception in the antenatal period because like I say they have got so many other things that they are thinking about." [Birth centre]

"It's in a more private setting [with the community midwife at Day 10] so they have more opportunity to discuss things more fully." [Postnatal ward]

"Sometimes they [GPs] don't broach the subject ... I think it definitely should be, otherwise things get missed." [Birth centre]

felt that women might feel uncomfortable discussing contraception with male GPs. Concerns regarding failure to attend the postnatal appointment were also mentioned.

Education and knowledge

Midwives reported receiving very little contraceptive education (Box 3). Some midwives recalled that this was briefly addressed during their initial midwifery training but others could not remember receiving formal contraceptive education at all.

There were variations in how midwives perceived their contraceptive knowledge. Most felt they weren't up to date, as new contraceptive methods had appeared since they qualified. Many said if they were asked a specific question about contraception they probably wouldn't be able to answer it. Despite many midwives reporting their contraceptive knowledge as poor, they felt they knew enough for the limited role they had. They felt that a lot of training would be needed to bring them up to a sufficient level to discuss contraception in detail, and that this was not feasible.

Box 3 Quotes from midwives talking about the contraceptive education they have received

"I've never had any formal family planning education, it's just what I've picked up along the way really." [Community midwife]

"Probably you hear more about contraception in the playground at school dropping the kids off than I do in here." [Postnatal ward]

"We did a small block when I was a student, it has probably all changed by now. But no, I haven't done anything since I qualified. We tend to concentrate on the delivery bit rather than prevention." [Postnatal ward]

"It's up to you I suppose about how much you know ... we don't get specific sort of training on it." [Birth centre]

Barriers and facilitators

The majority of midwives identified barriers to giving advice (Box 4) such as women not wanting to discuss contraception or women not being in a fit state to do so following childbirth. Lack of privacy on the wards and the presence of visitors were also mentioned. Inadequate time and the quantity of other information to impart to postnatal mothers were seen as barriers. Some midwives felt their knowledge levels were a barrier too.

Midwives felt that contraceptive training would be an important facilitator together with good-quality information leaflets to give to mothers. It was also considered that having time to get to know women before discussing contraception would help, so that women would feel more comfortable about having the discussion. Although some midwives found the presence of a women's partner a barrier, others thought it beneficial since they might take some responsibility for contraception.

Importance of advice

All midwives agreed that it was important that women receive postpartum contraceptive advice. Perceived benefits of giving advice such as increasing inter-pregnancy interval were mentioned, although unintended pregnancies were generally not considered to

Box 4 Quotes from midwives talking about their perceived barriers to discussing contraception

"The majority of women don't even want to think about it [contraception]." [Postnatal ward]

"People don't want to listen to it because they are in a bay full of other women so it's the last thing on their minds and they have got like a baby that's crying and not slept in so many hours so it's not a lot that goes through ... they are so tired ... they forget everything." [Postnatal ward]

"Women are so excited about their new baby that they don't want to listen." [Community midwife]

"A lot of them are like, 'oh I'll see my GP'. Some will brush you off and say, 'look I've had five babies before, I know what I'm doing'." [Postnatal ward]

"If she's got people in the room at the time you are doing the discharge like a partner, mother, you know, other relatives sometimes it can be more difficult to broach the subject." [Birth centre]

"If you are doing your chat and you know you have got another four to do, everybody is waiting so just your usual time." [Birth centre]

"There's so much information to kind of be giving them and they're too busy trying to pack." [Postnatal ward]

"You are in a four-bedded bay and you don't want to get too personal with people ... because here obviously everyone listens through the curtains." [Postnatal ward]

be commonplace following childbirth. Midwives did feel that certain groups of women would benefit from targeted contraceptive advice, such as teenagers or women with significant medical or social issues, although they generally did not think that targeting such women was their role. Health visitors, GPs, social workers and obstetricians were all mentioned as people who may be better placed to target these groups.

Midwife provision of contraception

Views on provision of contraception

No midwives currently gave out supplies of contraception although many had supplied women with condoms and contraceptive pills in the past. Some thought that supplying contraception was beneficial so that women wouldn't get "caught out" without contraception. Others felt it unnecessary because women could easily obtain contraception themselves and they felt that the early postpartum period was too soon for women to decide what contraception they wanted.

Thoughts on being trained to administer the contraceptive implant

Most midwives reported occasional cases where women on the postnatal wards got contraceptive implants before discharge from hospital. Midwives reported that they had to get a doctor to insert these, and that the availability of doctors in some instances, could be problematic. Most midwives agreed that LARC methods were more reliable than barrier methods and pills and some emphasised this to women. Midwives were asked how they would feel about being trained to insert the contraceptive implant. This was met with opposing views.

I think it would be great if we could, because we've got to wait all the time for doctors to come and do it ... and there's so few of them can actually do it. [Postnatal ward]

If it was decided that that was to be part of my job remit then that would be fine but I think that my job remit is pretty big at the moment, I've got enough to be getting on with. [Birth centre]

It's disgusting, I just don't like it. That whole actually doing an incision thing. [Postnatal ward]

Many midwives had strong opinions that their role was expanding and they were taking on more responsibilities of doctors. Those who thought it would be good to be able to insert the contraceptive implant did raise concerns that their job was already extremely busy and the amount of training that would be required to insert the implant and to maintain this skill would be considerable.

DISCUSSION

To our knowledge this is the first UK study to show midwives' experiences and views on giving

postpartum contraceptive advice. If the findings from our study are representative of midwives throughout the UK then it shows that midwives view their role in discussing contraception as a minor one and that due to heavy workload, lack of privacy and lack of knowledge that they are merely able to have a cursory discussion about contraception and to signpost women to other health professionals to get further contraceptive advice. Interestingly, midwives felt that the most appropriate health professional to discuss and provide contraception was the GP, rather than the obstetrician, although they did express concern that women may be reluctant to discuss this sensitive topic if the GP was male. It was clear that the role of providing contraceptive advice is not one that midwives feel they have been adequately trained for, and they feel out of their depth in discussing methods in detail. This is entirely understandable, particularly when one considers that medical eligibility for contraceptive methods in the postpartum period is complex.¹⁵ For many women waiting until the 6-week postnatal GP visit to discuss and initiate contraception may be too late. In addition, it is not clear if the GP will routinely raise the subject of contraception,¹⁶ especially since the NHS patient information website regarding the 6-week GP check-up says "you can ask about contraception".² This implies women have to initiate a contraceptive discussion themselves.

This study also showed that midwives find there to be many barriers to giving contraceptive advice; many of these have previously been identified many years ago.¹⁰ Women not wishing to discuss contraception was a common barrier; they are more concerned with advice relating to their baby¹⁰ or cannot imagine having sex again.¹⁷ Women also find discussing contraception embarrassing¹⁸ and lack of privacy on a shared ward may add to this embarrassment.

If the postpartum period is the wrong time to discuss contraception, then should it be discussed antenatally? The UK Faculty of Sexual & Reproductive Healthcare recommends that all methods of contraception should be discussed with pregnant women both antenatally and postnatally.¹⁹ There is mixed evidence for the effectiveness of antenatal contraceptive discussion.¹⁶ In our study, most midwives believed that an antenatal discussion about contraception would not be worthwhile. In a previous study conducted in our service of specialist antenatal contraceptive advice, women who received specialist advice had no higher rates of contraceptive use than women who did not receive this intervention.¹⁰ Although the latter study was undertaken 16 years ago, there have not been any new publications on postpartum contraceptive provision in the UK since then, perhaps reflecting a lack of interest in this part of maternity care over the past decade or so. However, there is some evidence from the USA that an antenatal discussion may be beneficial, in that it

could identify women who may wish to opt for provision of a LARC method that could be inserted in the immediate postpartum period before discharge from the hospital.²⁰ The availability of LARC at this time would also address the problem that many mothers find it hard to attend clinic appointments to get LARC methods inserted in the postpartum period,²¹ with the demands of caring for a newborn, sleep deprivation and recovering from childbirth.

One of the key outcomes of the sexual health frameworks of Scotland and England is fewer unintended pregnancies.^{22 23} An important recommendation is that LARC should be offered to women who are most at risk of unintended pregnancy including women using maternity services. Observational studies from the USA and New Zealand have shown that uptake of contraceptive implants by young mothers soon after childbirth is associated with a reduction in the numbers of women with short inter-pregnancy intervals.^{24 25} Although, it has been suggested that midwives could provide more contraception such as LARC,²³ midwives had mixed views on being trained to insert implants. If there are to be more women accessing LARC methods such as the implant from maternity services then clearly midwives (and obstetricians) will need to be better informed about these methods and trained to insert them. This will require engagement with SRH services so that maternity staff are appropriately educated about LARC and trained and supported to supply it.

The strengths of this study include the detailed nature of the qualitative interviews, as it has been shown that interviews are the most accurate way of getting accounts of people's experiences and views.²⁶ The fact that the interviews were semi-structured ensured that the relevant areas were covered while still allowing flexibility in content. A diverse purposive sample was obtained with midwives working in different settings and having differing experiences, giving a fuller picture. However, the community midwives were a self-selected group so may not be representative of all community midwives. Furthermore, the research was only undertaken in one region of Scotland and so may not be representative of all areas in the UK.

This study suggests that a combination of 'midwife' factors (such as lack of detailed contraceptive knowledge, heavy workload) and 'maternal' factors (such as preoccupation about the baby and fatigue) results in the postnatal contraceptive discussion in the immediate postpartum period with mothers being a cursory one. If midwives are expected to be effective as providers of quality contraceptive advice then they deserve ongoing training and support. This will necessitate close links between maternity services and SRH services, particularly if midwives are to take on more of a role in provision of contraception such as inserting implants.

Acknowledgements The authors would like to thank the midwives who participated in the study and Julia Lawton (Department of Population Studies, University of Edinburgh) for advice on methodology.

Competing interests None.

Provenance and peer review Not commissioned; externally peer reviewed.

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