The Cardiff postpartum family planning initiative: improving provision of postpartum contraception

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BACKGROUND

Unplanned, closely-spaced pregnancies increase the risk of maternal and child morbidity and mortality.[1] The Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Sexual & Reproductive Healthcare (FSRH) recommend that discussion and provision of contraception should be part of maternity care, including antenatal, intrapartum and postpartum care.[2 3]

The need for a robust postpartum contraception service has been highlighted through research from Edinburgh, where 96.7% of new mothers did not plan to conceive in the first year postpartum and 42.8% would use long-acting reversible contraception (LARC) if it were available before discharge.[4] Following this, a pilot postpartum contraception service demonstrated the benefits of antenatal counselling, but also highlighted numerous barriers to providing immediate postpartum contraception.[5]

WHY WAS THE CHANGE NEEDED?

An evaluation in the maternity unit of the University Hospital of Wales, Cardiff (approximately 6000 births per annum) found that 67% of new mothers planned to use contraception after delivery, but that none left the hospital with contraceptive supplies.[6] Vulnerable women, such as teenage mothers, are disproportionately affected by rapid subsequent unintended pregnancies in the Cardiff and Vale University Health Board area,[7] reflecting a wider issue with a lack of postpartum contraception provision. Women's contact with maternity services presents an excellent opportunity to discuss contraception and arrange its supply immediately following childbirth. External input was secured to enable a busy maternity unit to provide contraception straight after delivery and before discharge from hospital.

WHAT CHANGE WAS MADE?

In November 2016, a consultant midwife in public health collaborated with a consultant in sexual and reproductive healthcare (SRH) to create the Cardiff postpartum family planning (PPFP) initiative.

The Cardiff PPFP initiative has three aims:

1. To train midwives in antenatal and postnatal contraceptive advice and care
2. To develop information for pregnant women on their postnatal contraceptive options
3. To offer contraceptive supplies to every maternity patient before their discharge after delivery.

A mandatory contraception module was introduced to in-service training for all midwives. This was supported by informal clinical training on wards and formal one-to-one training to issue contraceptives via patient group directives (PGDs). These PGDs enabled trained staff on postnatal wards to supply progestogen-only pills (POPs) and a progestogen-only injectable (depot medroxyprogesterone acetate, DMPA). A postnatal contraception ward round staffed by doctors and nurses from SRH clinics was held on weekdays. Public Health Wales provided funding to produce new information leaflets and also for the contraceptives. With this setup, women could start their contraception, including LARC methods, during their stay in the maternity unit. The SRH staff were qualified to insert subdermal implants (SDIs), and two individuals had received training in postpartum intrauterine contraceptive (PPIUC) insertion. However, due to delay

in equipment supply and staff availability issues, no PPIUC devices were fitted during this initial period. Those interested in intrauterine contraception (IUC) were therefore offered bridging contraception and access to IUC in community clinics.

A patient information leaflet about postpartum contraception was produced to support the advice delivered in antenatal clinics and on the postnatal wards. Two particular antenatal visits were found most suitable for antenatal contraception planning: at the 16-week appointment to initiate the discussion and at 36 weeks to revisit the subject and decide on a likely method. The discussion could then be continued before postnatal discharge.

HOW WAS THIS CHANGE EVALUATED?

Postpartum contraception supplied

Service delivery of contraceptives was recorded after each postnatal ward round. During the initial 3 months of the project (January–March 2017), 1411 women delivered in this maternity unit. Of these, 233 (16.5%) left the hospital with contraception (table 1). This is a small percentage, but it demonstrates progress from the 2014 survey, when no women were discharged with contraception.[6] Further improvement is needed and is likely as the project continues and becomes more established.

Service data collection

Electronic maternity case records were examined to compare postpartum contraceptive provision before the project and during its first 3 months. This also indicated improvements in contraception discussions and provision. However, inconsistent data entry made this source unsuitable for analysis of the initial Cardiff PPFP activity. This episode has instead helped to address quality control and improvement of data transfer from handwritten clinical notes into the maternity database. Therefore, more accurate clinical data should be available to inform subsequent PPFP service reviews.

Training

During the first 3 months of the project, the consultant midwife (JC) single-handedly managed the training of midwives. In this time, 50 midwives (approximately one-third of all midwifery staff) participated in contraception training and 20 completed training for providing POPs using a PGD. Midwives receive ongoing support and mentorship from the SRH team and training of midwives to fit SDIs is planned for the future.

Table 1 Immediate postpartum contraception provided in Cardiff, January–March 2017.

Contraception method	Women supplied with each method (n)
Progestogen-only injectable (DMPA)	60
Subdermal Implant (SDI)	50
Progestogen-only pills (POPs)	123
Intrauterine contraception (IUC)	0
Total number of women leaving with PPFP supply	233

DMPA, depot medroxyprogesterone acetate; PPFP, postpartum family planning.

WHAT CHALLENGES DID WE FACE?

A small informal poll of midwives explored their views about the new initiative. Some stated that they still felt poor or borderline poor at discussing contraception with their patients, highlighting the importance of continued training. When asked to define the main barriers to immediate postpartum contraception, some midwives were concerned about suitable timing for the contraception discussion. It was felt that women were often too exhausted to discuss contraception immediately postnatally, reinforcing the importance of contraceptive counselling during the antenatal period.[8] Antenatal contraceptive counselling and provision of postnatal contraception started simultaneously in Cardiff. This meant that during this first 3-month period women on the postnatal wards had not benefitted from the new antenatal counselling. Therefore, we hope that in the future, postnatal women will be familiar with the subject and better prepared to decide on their contraception, reducing the time needed for counselling postnatally. The external support on the contraceptive ward round by members of the SRH team is important to ensure service provision and also training for midwives and obstetricians. However, the service remains limited to weekdays. Continued support is needed to train all midwives and obstetricians in PPFP provision, ensuring daily access to postnatal contraception in the future.

WHAT ADVICE WOULD WE GIVE TO OTHERS CONSIDERING TAKING SIMILAR ACTION AND WHAT ARE THE KEY POINTS FOR OTHERS LOOKING AT REPLICATING THIS SERVICE?

Learning curves were steep and the progress of training maternity staff will be slow, but we are some way towards achieving the overall goal of enabling midwives to fit SDIs, insert PPIUC and provide DMPA or POPs. The main focus of the PPFP initiative is to train midwives, as the future providers of most postpartum contraception. Recent FSRH guidance on competence for SDI fitting-only[3] presents welcome help to expand this training.

Informal discussions with maternity staff showed that while midwives were generally very enthusiastic about this intervention, obstetric medical staff appeared less so. Earlier recruitment of medical support for the PPFP initiative might have been beneficial. Training sessions for medical staff are being planned, particularly to promote PPIUC insertion during Caesarean section and following vaginal delivery. To ensure that

the current momentum continues, a multidisciplinary approach with input from SRH, midwifery and obstetrics and gynaecology is essential.

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Competing interests None declared.

Patient consent Not required.

Ethics approval As this was a new service followed by a service evaluation, formal ethical approval was not required. However, permission to conduct the evaluation was granted by Cardiff University and the local Obstetrics and Gynaecology Department.

Provenance and peer review Not commissioned; externally peer reviewed.

Data sharing statement Since this was not a primary research project, there are no data that can be shared.

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