Developing the role of midwives as 'contraceptive champions' to support early access to effective postnatal contraception for women

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ABSTRACT

Objective To evaluate the acceptability of the new contraceptive champion role to the first hospital and community midwives in NHS Lothian trained in this role.

Design Health service evaluation.

Population Hospital and community midwives trained as contraceptive champions, NHS Lothian, Scotland, UK.

Methods Qualitative research: 1:1 semi-structured interviews (baseline and follow-up) with five contraceptive champions.

Main outcome measure Qualitative data on views of the new contraceptive champions on the first 6 months of the role.

Results All contraceptive champions stated increased confidence in their knowledge of postnatal contraception. They reported that women had not questioned the role of midwives in inserting contraceptive implants postnatally in hospital and at home. Midwife colleagues and hospital doctors had been supportive.

Conclusion The new role of contraceptive champion is reported by midwives to have been well received in its first year by women, the midwives themselves and their healthcare colleagues.

Key messages

- The contraceptive champion role enables hospital and community midwives to advise on postnatal contraception and provide specific methods including insertion of contraceptive implants.
- Women have responded positively to being offered a contraceptive implant in hospital or at home by their midwife postpartum.
- Midwife colleagues and hospital doctors support the contraceptive champion role.

WHY WAS CHANGE NEEDED?

Access to contraception in the postpartum period can be difficult since the demands of a young baby and recovering from delivery take priority.[1 2] It has been usual in the UK for women to access postnatal contraception (PNC) from a general practitioner (GP) at a 6-week postpartum visit. While GPs can provide prescriptions for contraceptive pills, patches, rings and injectable at this visit, women who want a method of long-acting reversible contraception (LARC) such as the implant or intrauterine contraception (IUC) may need an additional visit to facilitate this.[3] Women may have resumed sexual activity and ovulation by 6 weeks postpartum and thus risk another pregnancy.[1]

The concept and role of a 'contraceptive champion' midwife was created in response to findings from the Access to Postpartum LARC in South East Edinburgh (APPLES) project where antenatal contraceptive counselling at 22 weeks gestation and provision of PNC following delivery for women demonstrated the need for more healthcare staff trained to insert implants and provide other PNC methods for women.[4] Evidence indicated midwife support for providing contraceptive counselling and methods provided they had appropriate and ongoing training to ensure their knowledge is up to date.[4 5]

Contraceptive champions are hospital and community midwives in NHS Lothian trained to advise women on PNC methods and to provide specific contraceptive methods including the insertion of contraceptive implants without an individual

prescription. The champions follow patient group directions (PGD), locally agreed criteria that permit suitably trained health professionals to provide specified medicines without a prescription. The PGDs in use permit supply of the progestogen-only injectable, progestogen-only pill and implant. Contraception (and insertion of a method if relevant) is provided at no cost throughout the National Health Service (NHS) in the UK, including NHS hospitals, community settings and from GPs.

HOW WAS THE ROLE OF CONTRACEPTIVE CHAMPION IMPLEMENTED?

Evidence of the acceptability of the role of a midwife with specialist knowledge of contraception and trained to insert implants was already available in NHS Lothian as a specialist midwife working for the PrePare Team (supporting women with substance misuse issues during pregnancy and 6 months afterwards) was already inserting implants for her clients in their homes.[6] Feedback was positive, with many women having a preference for contraceptive provision from their own midwife.[6]

To qualify as a contraceptive champion, midwives are required to achieve competence in implant insertion. This involves a recognised online training programme, provided by the Faculty of Sexual & Reproductive Healthcare (FSRH), and practical training sessions in the local Sexual Health Centre that equip the learner with evidence-based knowledge and skills necessary to consult with a woman requiring contraception and the practical training to provide appropriately a subdermal contraceptive implant inserter and to advise on management of contraceptive side effects.[7] The contraceptive champion must pass the FSRH online training e-Knowledge Assessment (eKA).

Counselling on PNC is offered to all women antenatally and enables them to get their choice of method in hospital, if appropriate. Hospital midwives who are contraceptive champions can provide the implant for women choosing this method while they are in a postnatal ward. Community midwives can provide this for women in the postpartum period in their home using a local coolant (ethyl chloride spray), an important fall back for those women who wish to have an implant inserted but who left the maternity service before this could be provided.[6] To date, there are 17 contraceptive champions (seven hospital and 10 community midwives) working in NHS Lothian.

We wished to evaluate the acceptability of the contraceptive champion role to midwives and so undertook semi-structured interviews with five contraceptive champions at the end of training and again after 6 months in the role. An average of 20 implants had been inserted by each champion over the 6 months.

Evaluation methods

- Qualitative research carried out as part of evaluation of the APPLES pilot project. A phenomenological approach was taken.
- 1:1 semi-structured interviews (baseline and 6-month follow-up) with five contraceptive champions (two hospital and three community midwives)* to examine the acceptability of the role (see online supplementary file 1 for interview schedule).
- Consent was taken from participants prior to interviews. Interviews were recorded with the permission of midwives, transcribed verbatim, anonymised, and coded and categorised using QSR NVIVO 10 by one researcher. Inductive thematic analysis was undertaken. Memos and reflective notes were used to limit researcher bias. Interviews took an average of 40 min.
- One researcher carried out data analysis due to limited resources. Common themes across participants indicated data saturation within this sample. Data were related to relevant findings from the wider APPLES evaluation to check dependability and constancy. Quantitative data are being gathered separately on the effectiveness of the role in relation to uptake and continuation of contraception and will be reported in due course.
- The researcher had no established relationship to the study participants.

*The intention was to train five hospital and 10 community champions within the timeframe of the study, however barriers (explored in the interviews) prevented this. The small number of contraceptive champions who had completed training at this time limited the number invited to participate. Invitations were sent to midwives on completion of their training until five were recruited, covering both hospital and community settings.

ACCEPTABILITY OF THE ROLE OF CONTRACEPTIVE CHAMPION

Midwives cited the desire to expand their skills and recognition of how easier access to PNC could benefit women as reasons for volunteering to train as a contraceptive champion. They reported continued enthusiasm for the role after the first 6 months and increased confidence in talking about contraception. When asked how women responded to the offer to provide implants, champions stated that provision of PNC was seen as one of a midwife's responsibilities, and women have not questioned the role of a midwife in inserting contraceptive implants.

> Yeah, they seem quite happy. They don't expect it to be done by a doctor or that, it just seems to be the normal for them.

The response to being offered the implant in hospital or at home by their midwife had been positive, reflecting existing evidence on its acceptability.[6]

> So the fact you can offer it in hospital, some of them, like, they really do jump at the chance to get it. …they were saying 'Oh this is a great thing, yeah, I wish I had this before and, you know, it's so easy. It's really kind of you to come to the house'. And you know, a few ladies, two younger girls, just said, 'Well I never ever would have gone to get that done. I'm so glad that you came'.

Asked if the role was viable alongside existing responsibilities, midwives reported that the 15–25 min it took to provide an implant was considered manageable within their workload, thus indicating that concern expressed in other research over the impact on workload was currently unfounded.[5] All had inserted more than the minimum 12 implants a year needed to maintain their skills.

> …the time that it takes to actually talk to people and put it in [Nexplanon], it doesn't take that long.

Support of midwife colleagues and hospital doctors was essential in establishing this role and contraceptive champions confirmed their backing. Cover from colleagues when inserting an implant for another midwife's patient had not been an issue.

> They think it's really good, yeah, and some have expressed interest in doing the course as well.

One hospital champion noted that other midwives are more likely to discuss the implant with women knowing a champion is available to give it.

> Um I think now it's easier and folk are more willing to offer, I think, the Nexplanon…Now that it's less hassle to get it for women. Knowing that if I am on the ward, I can go and do it, I think…and they don't have to then go chasing doctors, potentially have people waiting in beds.

CONCLUSION

Despite a slow start, the new role of contraceptive champion is considered by midwives to have been well received in its first year by women. The champions themselves are confident in their new role, and reported support from colleagues. It requires commitment from midwifery managers and support for training in contraception from SRH services to achieve this change and to provide ongoing mentoring. It also requires advocacy from the champions to ensure succession planning and thorough embedding of this role within midwifery teams. The FSRH eKA covers a range of sexual health issues and knowledge, arguably wider than what is necessary for the contraceptive champion role, and the need to pass this assessment has been a barrier for some prospective contraceptive champions. In acknowledgement of this, NHS Lothian, with support from the Scottish Government, is developing a specific online training module for Scotland, and it is hoped this will encourage more midwives to become contraceptive champions in the future as well as provide the theoretical background required for those midwives (and medical staff) who wish to undertake IUC insertion immediately postpartum.

Barriers to the development of contraceptive champions

Our evaluation revealed two main barriers to the development of contraceptive champions:

- It took 18 months from initial proposal to implementation due to obstacles including agreeing release of midwives for study, time to undertake the e-learning module, anxiety about failing the online eKA, and time to develop and approve contraceptive method-specific PGDs.
- Identifying the budget holder for contraceptive supplies and establishing transfer of supplies from the hospital pharmacy to community bases.

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