Putting contraception into maternity care

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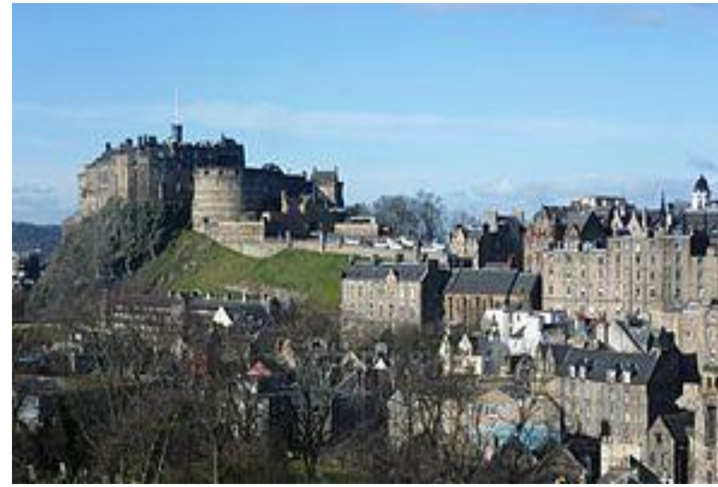


Queens Medical Research Institute:

Centre for Reproductive Health

Background

- Need for effective contraception underestimated
- Postpartum fertility & sex resumes quickly
- Postpartum unintended pregnancy
- 1 :13 seeking abortion gave birth < 1yr
- Inter pregnancy interval < 1 yr: risk preterm birth, neonatal death
- 1 :13 inter pregnancy interval < 1 yr

Heller et al JFPRHC 2016

Postpartum contraception model

- Postnatal discussion with midwife or doctor
- 6 week postnatal check

Post partum contraceptive advice and midwives

"I give very basic [contraceptive] information at the time I discharge but very very basic."
"Just say see your GP in 6 weeks time and be safe."

(Postnatal ward)

- Women don't want to discuss contraception
- Midwives lack of time, knowledge, privacy
- Very little contraceptive training/education

> *"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 a baby that's crying and they've not slept in so many hours...they are so tired...they forget everything."*
>
> (Postnatal ward)

McCance et al JFPRHC 2014

6 week postpartum GP Visit

- Contraception last on list
- Mums from deprived areas & young not attending
- Condoms, pills provided

- Implant ‘another’ visit
- Further waits for IUC (> 2 months)

Lunniss et al JFPRHC 2015

By 6 weeks postpartum

- Ovulation as early as day 25 not Breast Feed
- ~50% sex active by wk 6

McDonald & Brown BJOG 2013

- Exclusive BF rates at 6 wks
- Scotland & England (28%) Australia (39%)
- For many 6 wks too late !

Do mothers want immediate contraception ?

- Yes (postnatal survey n=250)
- 43% '*in theory*' would choose immediate implant or IUC

- Need to know options
- Need trained providers
- Need to be available

Heller et al JFPRHC 2016

Feasibility & acceptability of antenatal contraceptive counselling & provision of contraception after delivery

APPLES

Cameron et al BJOG 2017

APPLES

- Antenatal discussion 22/40
- Plan documented by 32/40

- Method provided from maternity
- Implant, injectable, POP, condoms
- IUC (c/section), or appointment for SRH

- Nov 13- Sep 15 (N=1369 women)

Hormonal IUCD (Coil)

The hormonal IUCD is a little, t-shaped device that is placed in your uterus (womb). It releases a small amount of hormone, called progestogen, which prevents sperm from getting through the cervix into the uterus and meeting up with an egg. It may give you lighter periods.

Advantages
- Lasts for up to five years
- >99% effective
- It can be removed easily
- Very low dose of safe hormone
- Quick return to fertility
- May have lighter periods
- Suitable for breastfeeding women
- 'Fit it and forget it.'

Disadvantages
- Possible irregular periods which take a few months to settle
- Must be inserted by a clinician.

When can I start using this after I have my baby?

The hormonal IUCD can be fitted either in the first 48 hours after delivery or four weeks later. This will be discussed by your midwife or doctor to plan the best time. If you have a planned caesarean section it may be possible to fit it at the same time.

Hormone Free IUCD

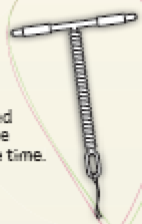
The copper IUCD is a little, t-shaped device that is placed in your uterus (womb) and alters the way sperm move. This prevents them from fertilising an egg. This type of IUCD has a small amount of natural, safe copper. It's 100% hormone-free and doesn't alter your periods.

Advantages
- Lasts for up to 10 years
- >99% effective
- It can be removed easily
- No hormones
- 'Fit it and forget it.'
- Continued regular periods
- Quick return to fertility
- Suitable for breastfeeding women.

Disadvantages
- Possible heavier, crampier periods
- Must be inserted by a clinician.

When can I start using this after I have my baby?

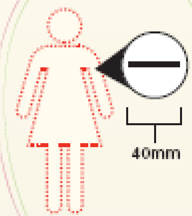
The copper IUCD can be fitted either in the first 48 hours after delivery or four weeks later. This will be discussed by your midwife or doctor to plan the best time. If you have a planned caesarean section it may be possible to fit it at the same time.



Implant

The implant is a tiny rod, about the size of a bendy matchstick that's inserted under the skin of your upper arm. The implant releases a hormone called progestogen that prevents your ovaries from releasing eggs and thickens your cervical mucus, which helps to block sperm from getting to the egg in the first place.

Advantages
- Lasts for three years
- >99% effective
- Quick return to fertility
- May have lighter periods
- Suitable for breast feeding women
- 'Fit it and forget it'
- Quick return to fertility.



Disadvantages
- Possible irregular periods (or no periods).

When can I start using this after I have my baby?

Immediately if you want to. We may be able to insert this at the time of caesarean section or on the postnatal ward before you go home. You definitely need contraception from three weeks after the baby is born.

Injection (Jag)

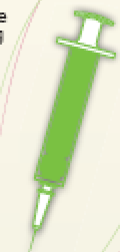
The jag is just what it sounds like, an injection that keeps you from getting pregnant. The jag contains progestogen, a hormone that prevents your ovaries from releasing eggs. It also thickens your cervical mucus, which helps to block sperm from getting to the egg in the first place.

Advantages
- Lasts for 3 months
- 94% effective
- May have lighter or no periods.

Disadvantages
- Must see a health professional every three months for the injection
- Possible delay in return to fertility
- Possible irregular periods.

When can I start using this after I have my baby?

If you are healthy and there are no complications during the pregnancy or birth that affect your health, then you can have this immediately. Otherwise you can get the jag at 21 days. Your doctor will advise you what's best.



Progestogen only pill

These pills contain only one hormone, progestogen. This method suits women who want to take pills but who cannot have estrogen. There are two kinds of progestogen only pill: the traditional ones that thicken cervical mucus and stop sperm reaching the egg and the newer ones that keep the ovaries from releasing an egg. Your doctor or nurse will help you decide which one would suit you best.

Advantages
- 91% effective
- Reversible after stopping
- Suits breastfeeding women
- Safe for women who cannot have estrogen
- May have no bleeding.

Disadvantages
- May have irregular bleeding
- Must remember to take at the same

Combined hormonal contraception

These methods contain two hormones, estrogen and progestogen, that prevent your ovaries from releasing an egg. Usually this is a pill that you take at the same time every day. There are lots of different kinds of pills on the market. You will need a prescription from your healthcare provider.

Sometimes women will use patches or vaginal rings which work just like the pill.

Advantages for these methods
- 91% effective
- Shorter, lighter and less painful periods
- Reversible after stopping
- May help with acne.

Disadvantages
- May have irregular bleeding, usually

Female sterilisation

This involves blocking the fallopian tubes so that sperm cannot get through to meet an egg. There are different ways of doing this. You will need to have it done in hospital.

If you are thinking about having female sterilisation you should speak to your doctor as soon as possible so they can advise you about what your options are.

Remember that the IUCDs and implant mentioned in this leaflet are at least as effective as female sterilisation.

Advantages
- Permanent
- >99% effective
- No change in periods.

Disadvantages
- Higher failure rate if done during

Male sterilisation – Vasectomy

This involves blocking the tubes (vas deferens) that take sperm from the testicles to the penis. It is a quick procedure done under local anaesthetic. It can be done in a community clinic. To arrange this you should ask your GP for a referral to Chalmers Sexual Health Service. Male sterilisation is more effective than female sterilisation and a much simpler procedure.

Remember that the IUCDs and implant mentioned in this leaflet are at least as effective as male sterilisation.

Advantages
- Permanent
- >99% effective
- Local anaesthetic.

Contraception Following Birth

There are some very effective and safe methods of contraception that are ideal for women who have just had a baby and want to space their pregnancies or who want long term contraception. Your midwife will discuss this with you during one of your antenatal visits so that you can have your contraception ready to start as soon as you have your baby. Staff in the hospital, or community, will make sure you can get your chosen method easily and quickly. You should definitely have started using some form of contraception by 3 weeks after the baby is born.

You can download this leaflet which provides information on contraceptive options, after you have had a baby.

To find out more about the long acting methods please watch this short film where you can see what the implant and coil (IUCD) look like and also see an implant being put in.

Women’s views on antenatal contraceptive counselling (survey)

- N= 1006 surveys; N= 710 return (71%)

	Yes	Helpful?
Discussion	78%	74%

73% ‘about right time’ (22 wks)

Contraception

Method	Planned % **43% LARC**	Provided % **9 % LARC**
Implant	**21**	**5**
IUC	**16 ***	**2**
Injectable	**6**	**2**
Pills	24	3
Condoms	26	1
None	19	86

* < 50% attended appointment for IUC fitting at SRH

Qualitative research

Community Midwives:

- Contraception counselling part of their role

Hospital midwives:

- Short hospital stays, busy weekends & wait for trained implant fitter

Obstetricians:

- Recognise benefit provision from maternity
- Implant takes time, support midwives training

Feasible, acceptable but challenging….

..rolled out to all region 2015

Contraceptive champions

- Midwife with contraceptive expertise
- Champion(s) in each postnatal and community midwifery team
- PREPARE midwife (substance addiction)
- Family Nurse Partnership

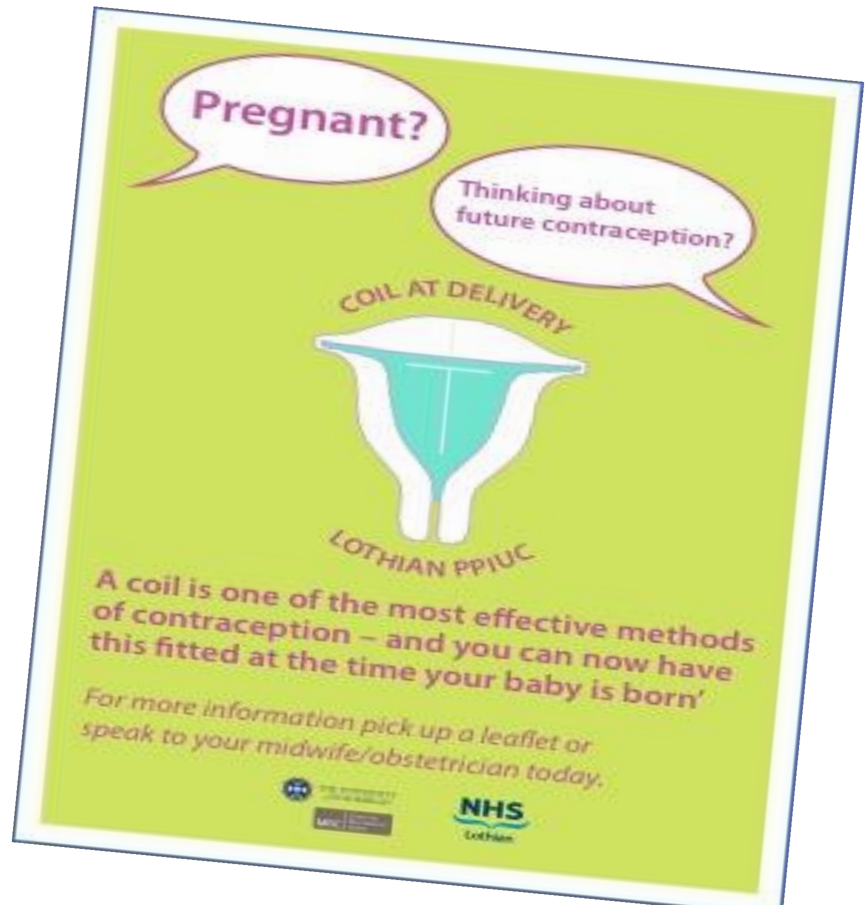
(< 20yr women & girls)

- Implant at home service

Croan et al BMJ SRH 2018
Gallagher et al BMJ SRH 2019
Gallimore et al BMJ SRH 2019

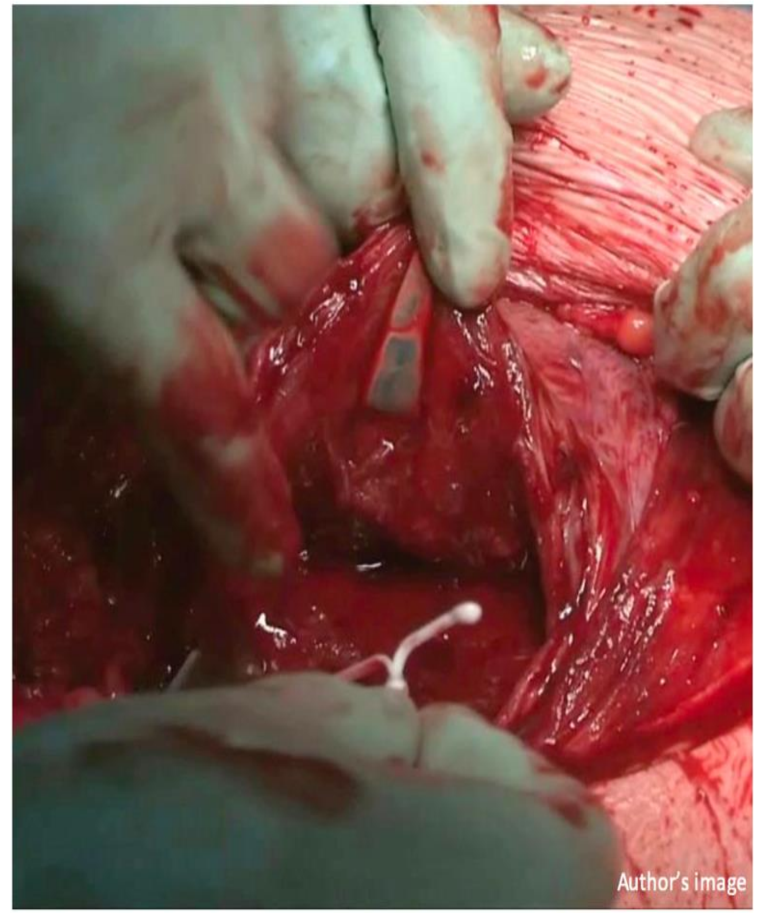
Immediate Post Partum IUC

- IUC within 48 hrs of birth
- C/section or vaginal
- Safe and effective
- Convenient
- Analgesia on board
- Routine in many countries



PPIUC at C-section

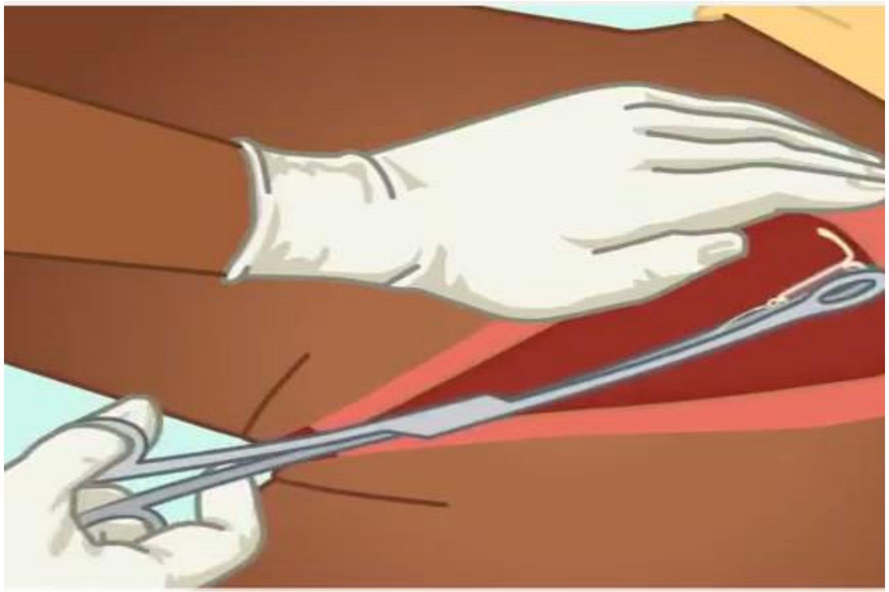
- Routine since July 2015
- > 1100 women
- (**14% all elective CS**)
- 70% LNG-IUS : 30% Cu-IUD
- Safe, low complications
- 8% expulsion, no perforation
- 85% continuation 1 yr



Heller et al Acta Obstet Gynecol Scand 2017

PPIUC vaginal birth

- Trained obstetricians & midwives
- Different technique High fundal insertion
- Kellys placental forceps
- Train obstetricians & midwives
- Sufficient staff to provide 24 hr cover



PPIUC at vaginal birth

- 300 women
- Review at 6 wks
- Telephone 3/6/12 months
- Uptake, complication and continuation rates
- Qualitative research women & staff

CHIEF SCIENTIST OFFICE
WELLBEING OF WOMEN

Training

- RCOG 'Leading Safe Choices'
- Theory, model simulation & supervised practice
- Obstetricians & labour ward midwives
- Community midwife updates
- GP updates

leading
SAFE
choices

Vaginal PPIUC

- Introduced Jan 2017
- > 550 women (**4.9% SVD**)
- Safe, low complications
- No perforation
- Higher expulsion
- 82% reinsertion
- 75% IUC at 3/12

Cooper et al 2019

- FIGO > 36 000 PPIUD
- Expulsion 2.6%, no perforation

Makins et al IJOG 2018

COIL AT DELIVERY
LOTHIAN PPIUC

Staff views on PPIUC

- Positive about service
- Perceived not affect birth experience, less pain
- Concerned about workload but views shifted over time
- Midwives embraced 'holistic care' to women

Women’s views on PPIUC

“All done at same time so you don’t need to worry about it…I probably wouldn’t have gone otherwise”

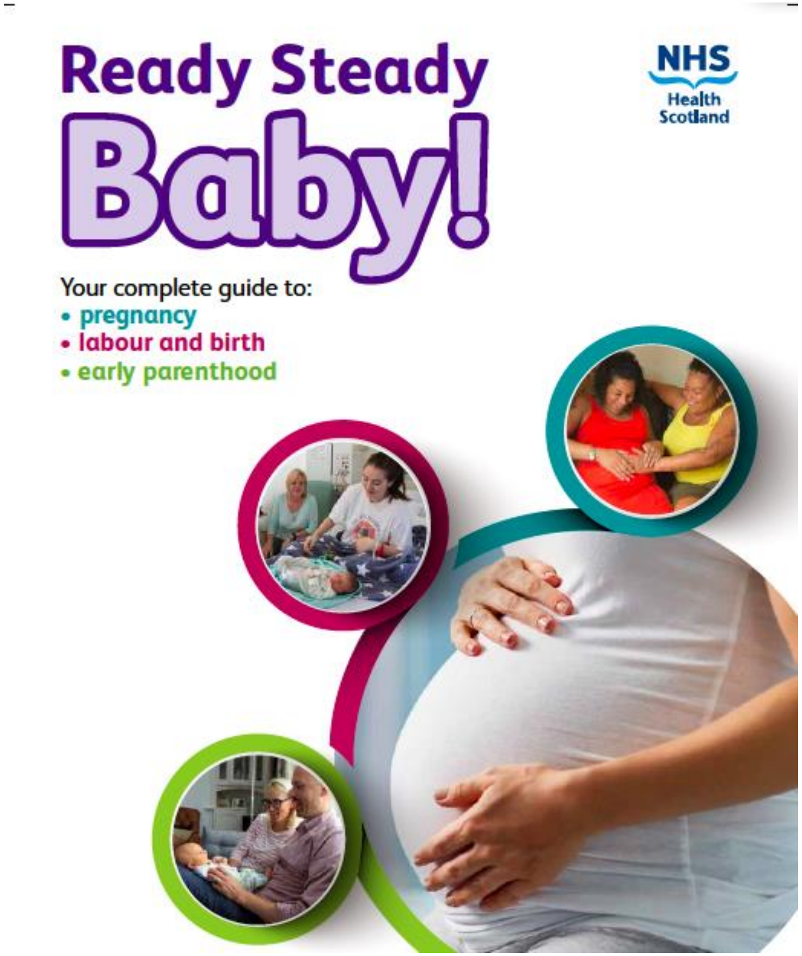
“Would have been great if it had stayed in!”

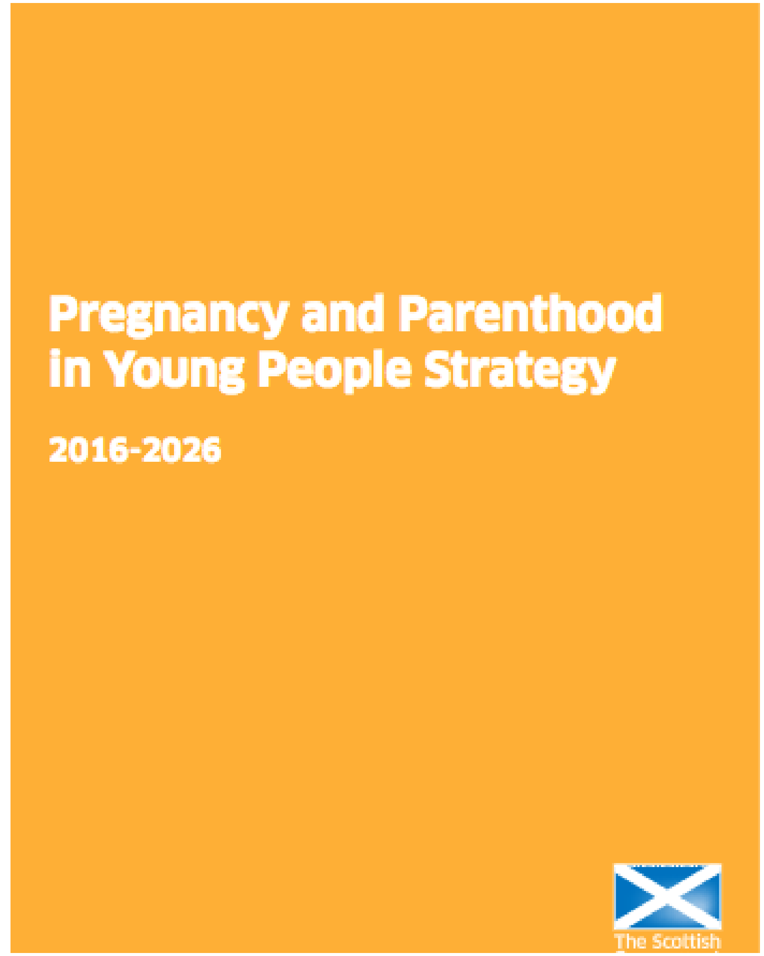
“Was bit sore at the time but I’m glad now I got it”

“Good that you can get it done straight away because you’re sore anyway and have pain relief on board…didn’t feel a thing!”

“Not sure I would have come back to get coil fitted otherwise”

Antenatal contraceptive counselling & method provision





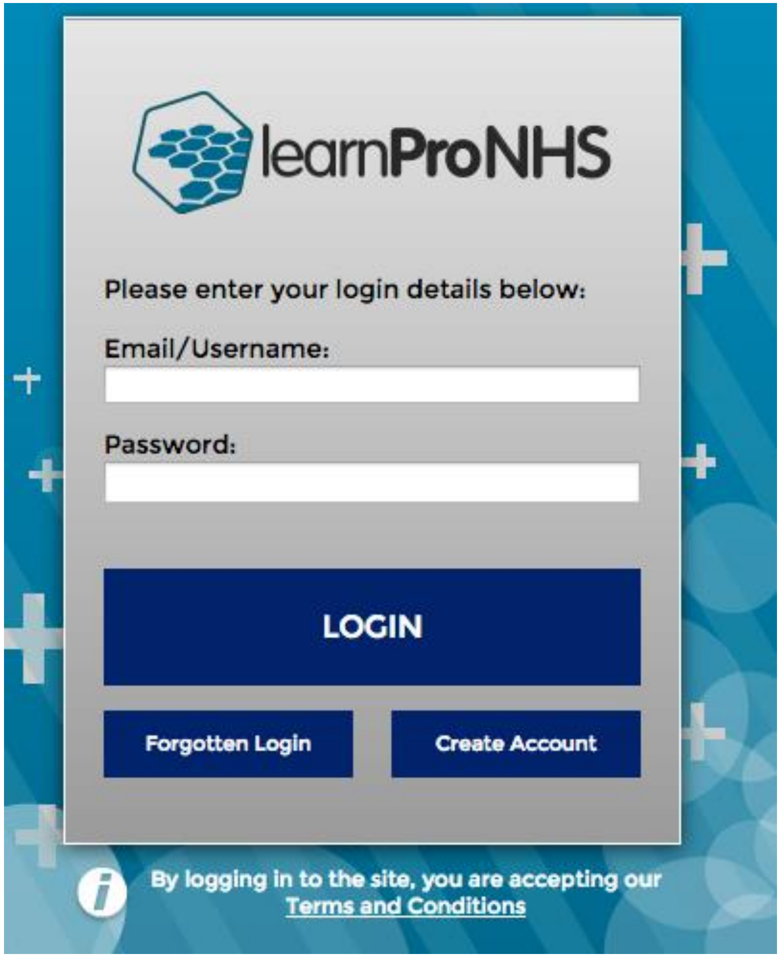
Contraception training maternity staff

Scottish Postpartum Contraception Meeting

Friday 27th September 2019

Royal College of Physicians, 9 Queen Street, Edinburgh, EH2 1JQ

9.00-9.30 am	**Registration and poster viewing**	
9.30- 9:40	**Welcome and introduction**	*Professor Sharon Cameron*
Session 1 9.40-11.00	***Postpartum contraception: from policy to practice***	**Chair: Felicity Sung**
9:40-10.10	Putting contraception back into maternity care	*Professor Sharon Cameron NHS Lothian*
10.10-10:30	From research to reality: implementation of postpartum intrauterine contraception (PPIUC)	*Dr Michelle Cooper NHS Lothian*
10:30- 10:50	The global context of postpartum contraception	*Dr Anita Makins FIGO*
11.00-11.30	**Refreshment break & poster viewing**	
Session 2 11.30-12.45	***Expanding the role of the maternity provider***	**Chair: Frances McGuire**
11.30-11.45	Training and links with sexual health services	*Alison Craig, NHS Lothian*
11.45-12.00	Becoming a midwife 'contraceptive champion'	*Lesley Scott, NHS Lothian*
12.00-12.20	Experience of PPC pilot sites: progress update	*NHS GGC/Ayshire&Arran (TBC)*
12.20-12.45	Hot topics: Improving access for hard to reach groups 1) Young people & role of Family Nurse Partnership 2) Ethnic minority groups	*Helen Cockburn + FNP client* *Annette Gallimore*
1245-13.30	**Lunch & poster viewing**	
Session 3 13.30-14.30	***Afternoon workshops* (choice of 2 to attend)**	**Facilitators**
Workshop A	PPIUC insertion techniques x 2	*Karen McCabe, Shiona Coutts, Michelle Cooper, Karen Black*
Workshop B	Implant insertion 'taster' session	*Alison Craig, Claire Nicol, Yvonne Cunningham*
Workshop C	*'Which method when?'*: Practical guidance for contraception after childbirth and UKMEC	*Dr Sarah Hardman, FSRH Clinical Effectiveness Unit*
14.30-14.50	**Refreshment break & poster viewing**	
Session 4	***Challenges and future developments***	**Chair: Dr Pauline Lynch**
14.50 - 15.10	Facilitators and barriers to PPIUC service delivery: experience of women and staff in Lothian	*Jeni Harden/Nicola Boydell, University of Edinburgh*
15.10 - 15.25	Launch of new e-learning resource for Postpartum Contraception	*Claire Nicol, NHS Lothian & LearnPro Representative*
15.25 - 16.05	**Panel session**: Postpartum Contraception - your questions answered	*Panel members: TBC*
16.05 - 16.15	Best poster presentation & Closing remarks	*Professor Anna Glasier,*



Best Evidence Guidelines

- Contraceptive counselling should be available antenatally
- Contraception should be initiated by 21 days
- Can be initiated immediately following childbirth if desired and medically eligible

Implementation challenges

"If you want to go quickly, go alone.
If you want to go far, go together."

African proverb

Challenges for implementation

- Combined efforts from range health care professionals, hospital leaders, researchers, women, policy makers
- SRH key role
- Need to 'champion' policy makers on health benefits for women
- Train maternity care staff on postpartum contraception
- Develop resources, protocols, processes, pathways
- Clinical leadership with support multidisciplinary team

Conclusion

- Need for effective contraception after delivery been underestimated
- Contraception routine maternity care
- Most effective methods uptake increasing
- Prevent more unintended pregnancies
- Optimise birth spacing
- Better outcomes for women & babies

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