

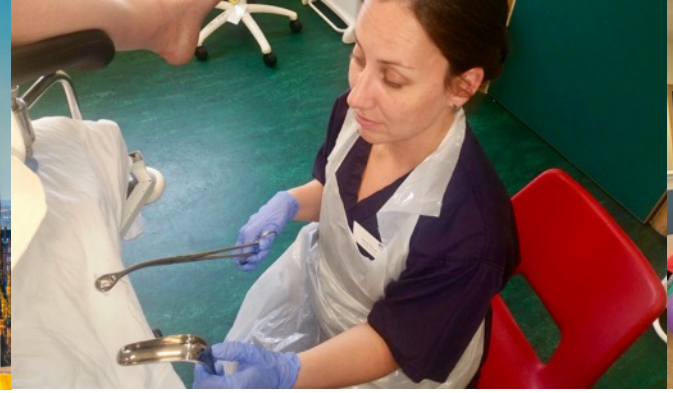


Simplifying access to contraception after pregnancy

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Unintended pregnancy

- Up to 50% pregnancies unintended at conception
- Some end in abortion
- Others result in miscarriage, ectopic pregnancy, live birth
- Opportunity to discuss future fertility intentions
- Unmet need for contraception?

Bearak et al, Lancet, 2018

Contraception after abortion

- 90% ovulate within 1 month, 50% resume sex within 2 weeks
- Most methods safe to start immediately
- Immediate initiation LARC = increased continuation, reduced risk unintended pregnancy at 1 year
- Women value discussion, motivation high, caution re coercion
- Telemedicine - reduced F2F opportunities, rethink models of care, audiovisual tools

Korjamo et al, BJOG, 2017
Purcell C et al, Contraception, 2015
Boesen HC et al, AOGS, 2004

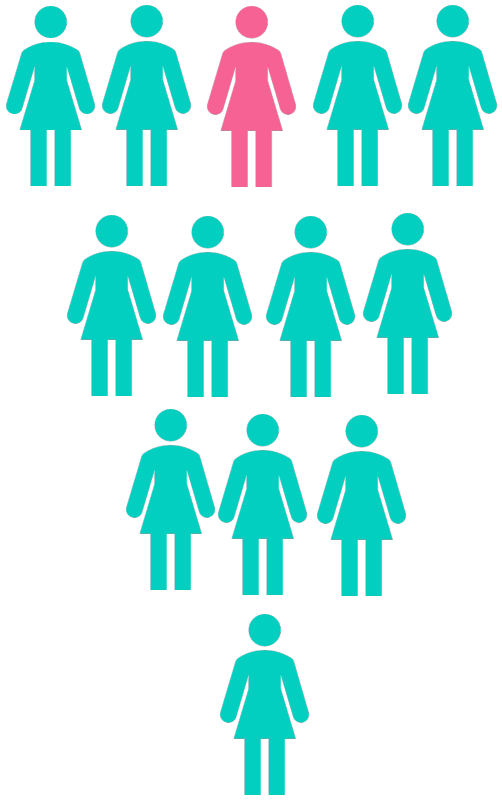
Contraception after pregnancy loss

- Up to 50% unintended, fertility intentions can change
- No need to delay after miscarriage, some may choose to
- 40% uptake contraception; 2-fold increase if unplanned
- Avoiding pregnancy may be recommended
  - MTX for ectopic pregnancy, hCG resolution post GTD
- Possible provider hesitancy, specific training needs
- Further explore needs of women

Roe et al, Contraception, 2020
Narayanan et al, BMJ SRH, 2022

Contraception after childbirth

- 97% do not intend further pregnancy within next year
- Ovulation as early 3-4 weeks, 50% resume sex by 6 weeks
- UK: 1 in 13 abortion within 12 months childbirth
- Short inter-pregnancy interval < 1 year
  - Preterm labour, SGA, low birthweight, stillbirth, neonatal mortality
- WHO recommends minimum 24 months



Heller et al, BMJ SRH 2016
Smith et al, BMJ 2013

When to discuss?

- GP 6-week postnatal review
  - Low priority, limited time
  - Additional visits for LARC, high rates non-attendance
- Shift focus towards maternity care providers
- Postnatal ward
  - Busy, lack of privacy, limited time for full discussion, other priorities
- Antenatal period
  - Multiple HCPs, more time for discussion & planning
- BUT….needs to be partnered with provision of methods
- Most methods safe to start immediately – convenience, overcome barriers

Challenges to providing PPC in maternity

- Limited training/education
- Myths/misconceptions around methods, safety etc
- Rapid turnover of staff
- Busy and unpredictable clinical environment
- 24/7 provision
- Lack of evidence re implementation
- Cost, insurance cover

“Postpartum contraception often gets forgotten about, and accidents happen! Implementation is another matter though.....”

Consultant Obstetrician
(2018 RCOG Member survey)

BJOG An International Journal of Obstetrics and Gynaecology
Royal College of Obstetricians & Gynaecologists

Original Research | Full Access

Feasibility and acceptability of introducing routine antenatal contraceptive counselling and provision of contraception after delivery: the APPLES pilot evaluation

ST Cameron, A Craig, J Sim, A Gallimore, S Cowan, K Dundas, R Heller, D Milne, F Lakha

First published: 05 April 2017 | https://doi.org/10.1111/1471-0528.14674 | Citations: 29

- AN discussion CMW at 20-22 weeks, increased methods on PN ward
- Surveys of women (n=794), FGDs with staff
- 74% had discussion - most found it helpful and timing acceptable
- 44% (n=341) wished LARC method - 9% received

"We just automatically think 22-weeks LARC, now it's just what happens…."

Community midwife (APPLES study)

Postpartum implant insertion

- Safe, acceptable, reduced risk short IPI
- 6X reduction in pregnancy risk next 12 months
- Lengthy and costly training can be a barrier – simplified ‘on-site’ training
- Innovative practice change
  - CMW contraceptive ‘champions’
  - Home implant insertion using ethyl chloride spray

“…getting a doctor to do the implant because they're (the woman) not willing to wait, because they're dying to get home”

Hospital midwife (APPLES study)

Cameron et al, BJOG, 2017
Tocce et al, AJOG, 2012
Croan et al, BMJ SRH, 2017

Immediate PPIUD insertion

- UK survey (n=250) - 1/3 would choose
- Caesarean or vaginal birth (<48hrs)
- Safe, convenient, may be less painful
- Increased expulsion rate
  - Vaginal > CS, <5% overall FIGO
- Highly cost effective
- Not routinely offered in most of Europe
- Perceived barriers – lack experience, training, implementation

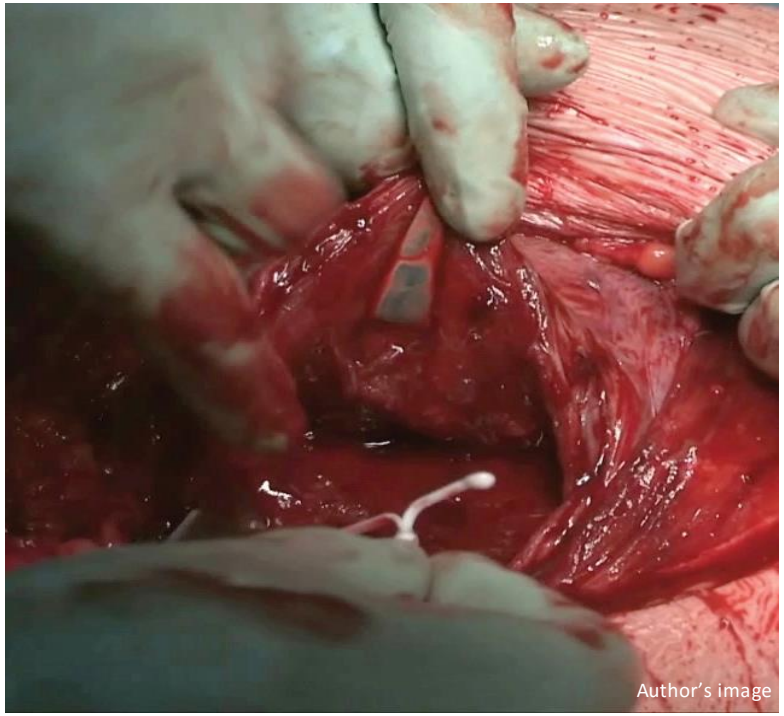
Sonalkar & Kapp, 2015; Makins et al, 2018; Heller at al, 2016; Washington et al, 2015

PPIUD at caesarean

- Introduced 2015 to Edinburgh
- 1st 300 women at 12 months
  - Uptake = 13.8% (elective) – increased since
  - Suspected infection = 3.8%
  - Uterine perforation = 0
  - Expulsion rate = 8.0%

➢ **79.1% continuation IUC at 12 months**

- 50% non-visible threads at 6/52 check
- ? Difficult to remove - <6% hysteroscopy

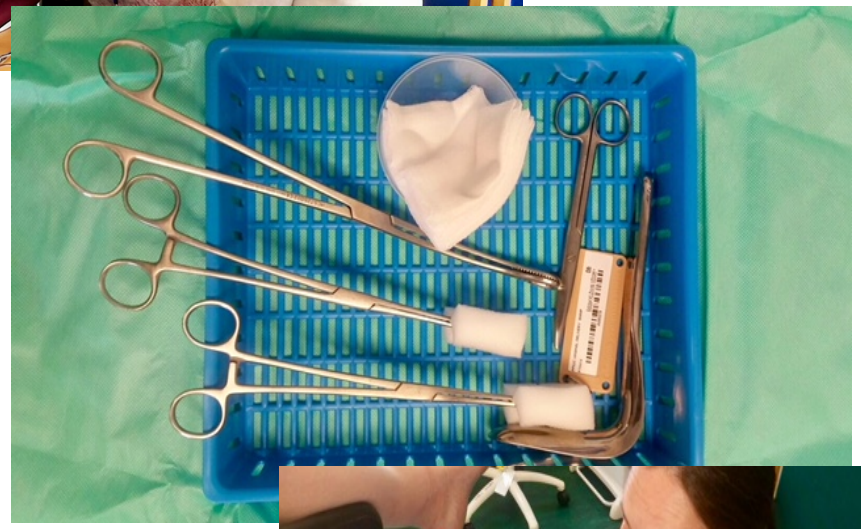


Heller et al, AOGS, 2017

PPIUD at vaginal birth

- Introduced in 2017
- Training – video, simulation, supervised practice using Kellys forceps
- Uptake: 4.9%
- 76% performed by midwives
- Outcome/complications (n=447):
  - Infection <1%, no perforations
  - Complete device expulsion = 29%
  - Reinsertion after expulsion = 88.2%

➢ **83% continued use of IUC at 12 months**



Cooper et al, AOGS, 2020

Women's experiences of PPIUD insertion

'They were like, "you can get it done within 48 h after giving birth", which I thought was great, you know, easier than having to … after 6 weeks having to go out to the GP, which isn't always easy to do with a baby, 'cause you might need someone to look after them.'
(Laura, age 20)

'It's the convenience of it that's probably the best thing about it, because if I never got it done then I would've never went back and got that option at a later stage, I don't think…'Cause I was in that position then and there I was like, "well, I'll just get it done" '
(Danielle, age 22)

'Fine. I didn't feel a thing [laugh]! So, after all that and all the worries, so I had good puffs of gas and air and, yeah, I honestly didn't feel it at all, not a thing, so it was absolutely fine.' (Mhairi, age 31)

Boydell et al; EJCRHC 2020

Implementation science is commonly **defined** as the study of methods and strategies to promote the uptake of interventions that have proven effective into routine practice, with the aim of improving population health

(UCL Institute for Global Health)

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SUPPLEMENT ARTICLE

WILEY GYNECOLOGY OBSTETRICS FIGO

Successful implementation of immediate postpartum intrauterine contraception services in Edinburgh and framework for wider dissemination

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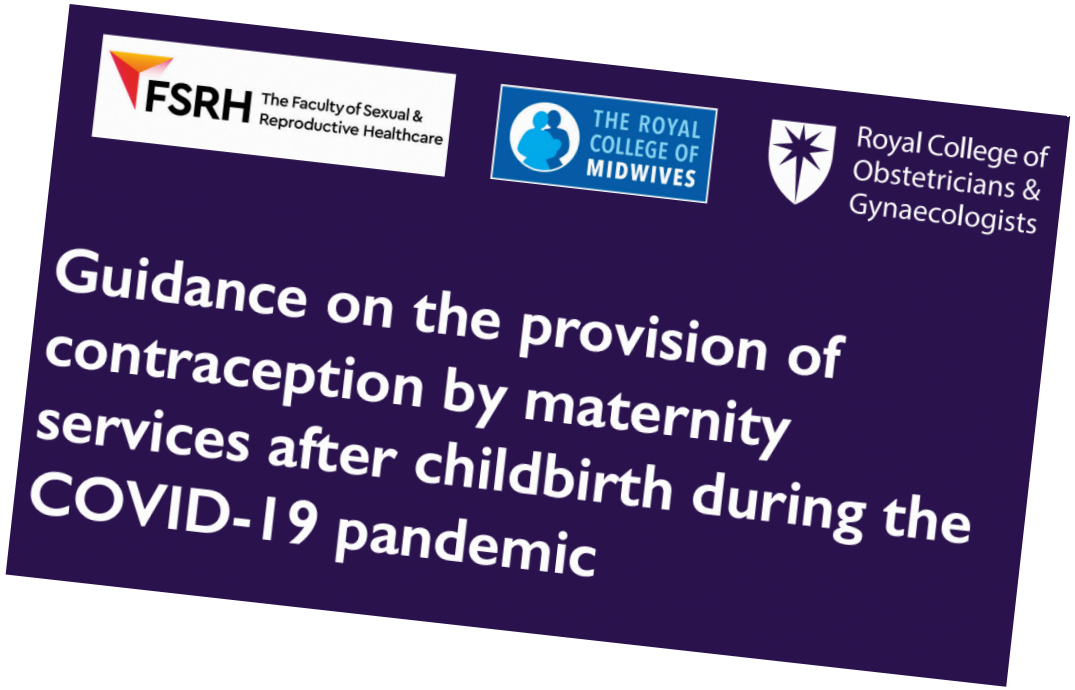
Abstract

Provision of immediate postpartum intrauterine device (PPIUD) insertion within maternity settings can overcome many of the barriers faced by women in accessing this method after childbirth. Uptake of PPIUD can help reduce the risk of a subsequent unintended pregnancy and improve spacing between births. PPIUD insertion is not yet routinely available in the UK and evidence to support the practical implementation of the service in this setting is lacking. Shared learning and experience of providers may assist in the wider availability of PPIUD. A routine PPIUD service has been successfully established within a public maternity setting in Edinburgh (UK) and this article utilizes an implementation framework to discuss the approach.

Impact of COVID-19

- Reduced community provision of contraception
- Barriers to access increased
- Affects those at highest risk UIP/short IPI
- Catalyst to enhanced provision with maternity
  - Staff redeployment, emergency funding
  - Sustainability?



European survey of postpartum contraception provision

- Azerbaijan
- Albania
- Armenia
- Andorra
- Belarus
- Bosnia & Herzegovina
- Macedonia
- Montenegro
- San Marino
- Slovakia
- Spain
- Ukraine

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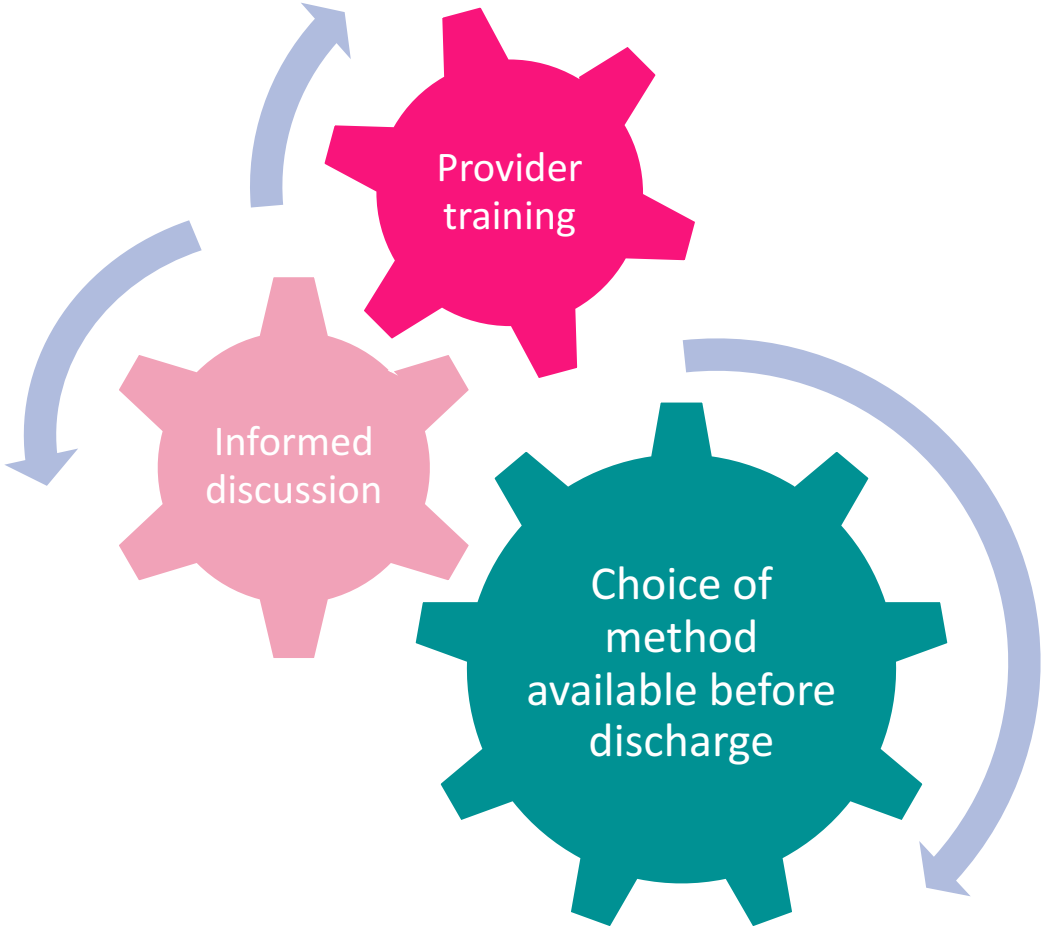
In summary…

- Many pregnancies are unintended
- Women value opportunity to discuss fertility/contraception
- Clinician ‘champions’ are key
- Discussion needs to be partnered with efficient provision of methods
- Novel methods of service delivery & training, digital technology



CAMPAIGN - TRAIN - SUSTAIN

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