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Evidence Briefing

What does the evidence say about the delivery and receipt of post-natal contraception in healthcare settings?

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27th July 2017
What does the evidence say about the delivery and receipt of postnatal contraception in healthcare settings?

**Question**

This briefing summarises the evidence on the delivery and receipt of postnatal contraception in healthcare settings, from January 2003 to March 2017.

**Key messages**

- The postnatal period is a high risk time for unintended pregnancy
- There is unmet need for postnatal contraception, particularly amongst vulnerable women such as, teenagers and young people, those with addiction and mental health problems, and those with multiple complex needs
- Healthcare professionals need more training and support to deliver safe and effective contraceptive care.
- Long acting reversible contraception (LARC) is the most effective method of contraception but is often underutilised
- There is a discrepancy between women expressing an interest receiving LARC and then going on to actually receiving it
- The 6 week post-partum visit is often too late to provide post-partum contraception care as many women resume sex in the interim
- Women should receive information about the range of contraceptive options and the most effective method of contraception during the antenatal and postnatal periods
- Whilst there is evidence on how receptive women are to postnatal contraception, there is little discussion in the literature about what influences their choices

Evidence briefings are a summary of best available evidence that has been selected from research using a systematic and transparent method.

**What doesn’t this briefing do?**

The findings from research papers summarised here have not been quality assessed or critically appraised.

**Who is this briefing for?**

This briefing is for Dr Annette Thwaites (secondee to the Healthy People Division) to inform her primary research into the attitudes of women to postnatal contraception. It will also be used to inform policy and practice.

**Information about this evidence briefing**

This briefing draws upon a literature search of the sources Embase, CINAHL, Medline and HMIC from 2003-2017

72 highly relevant citations were used to produce this evidence briefing. 70 additional papers were considered to be ‘of interest’ and details can be obtained on request.

You may request any publications referred to in this briefing from libraries@phe.gov.uk

**Disclaimer**

The information in this report summarises evidence from a literature search – it may not be representative of the whole body of evidence available. Although every effort is made to ensure that the information presented is accurate, articles and internet resources may contain errors or out of date information. No critical appraisal or quality assessment of individual articles has been performed. No responsibility can be accepted for any action taken on the basis of this information.
What does the evidence say about the delivery and receipt of postnatal contraception in healthcare settings?

**Background**

Unintended pregnancy is estimated to account for 80 million of the 210 million pregnancies that occur worldwide each year (1). In the UK it is estimated that 30% of pregnancies are unplanned(2). A short inter-pregnancy interval and unplanned pregnancies are associated with adverse maternal and child health outcomes (3-5). The postpartum period is a high risk time for unplanned pregnancies with many women resuming sex before their normal six week post-partum check, when postnatal contraception is usually discussed and they can access various contraceptive methods. Some women also do not attend their scheduled postnatal visit with their healthcare provider and the opportunity to deliver counselling and contraception is then missed. To achieve optimal spacing and improve health outcomes for mothers and infants postnatal contraceptive care needs to be provided (6).

There is a paucity of evidence on the provision and receipt of postnatal contraception amongst British women, much of the available evidence refers to populations in other countries such as the United States, Canada, India and Turkey. However, many of the issues relating to the delivery and receipt of post-partum contraception are common to women in all countries where research has been undertaken, including the UK.

**Vulnerable groups**

Whilst postpartum contraceptive care should be provided to all multiparous women, it is clear from the evidence that some women are at increased risk of short inter-pregnancy intervals and unplanned pregnancies. The evidence points to a number of vulnerable groups and suggests that postnatal contraceptive services should target these groups in particular.

- Those who are socially disadvantaged can find it difficult to access contraceptive services (7).
- Teenagers, young women and women from socially deprived backgrounds are less well informed about the contraceptive options available to them and many teenage pregnancies result in abortion (8-11).
- Women who have had a preterm birth have between and two-fold and six-fold greater risk of having another preterm birth due to a short inter-pregnancy interval (7).
- Women with severe maternal morbidity or pre-existing co-morbidity have an increased need for immediate effective contraception as they recover from severe pregnancy-related morbidity (12)
- Women suffering from addiction, mental health problems, domestic violence or with multiple complex needs are at increased risk of unplanned pregnancies (13-15).
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Women with multiple complex needs have a range of problems and often have chaotic lives that means that they do not consider contraception, or that makes adhering to the regime of taking oral contraceptives regularly difficult. These women frequently have their children taken into care as a consequence and this in turn can lead to poor health outcomes for their children (13, 14).

The evidence shows that there is a significant and largely unmet need for postnatal contraception amongst these vulnerable groups (16).

**Barriers to provision and use**

The evidence identifies a number of barriers that prevent women from accessing contraceptive services and using the most effective contraceptive methods.

Many women, particularly young women and those from socially disadvantaged backgrounds, do not recognise the risk of pregnancy during the post-partum period and lack knowledge about the different contraceptive methods and their efficacy (11, 17, 18). Many women miss their postpartum visit and therefore miss out on receiving counselling and access to contraception during this critical time (19-21).

A number of papers cite cost, for example the lack of health insurance, as a barrier to women accessing contraception (20, 22). Whilst in the UK contraceptive services provided by the NHS are free at the point of care, and upfront costs are not an obvious barrier for women in the UK, it is still worth noting that from the point of view of service delivery, any upfront costs represents an a significant barrier to access and use (7, 19, 23, 24).

Another barrier highlighted by the evidence is that some healthcare professionals do not consider postnatal contraception to be of enough importance and do not allow adequate time to discuss it during the post-partum period(8). Others, for reasons that are not entirely clear, are reluctant to provide LARCs to eligible women (19, 25).

Some midwives have expressed the view that there is not enough privacy in the postnatal ward for them to discuss contraception with the women they support. They assert that the presence of partners and family in the ward can be off-putting for some women (26).

Inadequate contraceptive counselling and advice is also a significant barrier to the use of contraception (15, 27, 28). The research shows that a lack of time, knowledge and confidence is hindering midwives’ ability to provide accurate and safe contraceptive counselling and advice (26, 29).

**Timing of advice and contraception**

There is a certain amount of disagreement amongst healthcare professionals about when the optimal time to provide counselling and advice on postnatal contraception is. According to some, women are not receptive to information just after birth.
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because they are pre-occupied with their new baby and there is little time to properly consider their options (11, 30). They argue that it would be better to provide counselling and advice during the antenatal period (31-33). Others argue that it is necessary to provide counselling and advice during the postpartum period as women are more motivated and likely take up effective contraception (16, 34). The obvious conclusion to be drawn is that postnatal contraception counselling and advice should be provided during the both the antenatal and postnatal periods (35).

The six week postpartum check or visit is commonly the first opportunity for a woman to discuss postnatal contraception with her healthcare provider but the message from the literature is that six weeks is frequently too late because some women have resumed sex in the interim (5, 26, 36). The evidence suggests that women should be counselled and offered contraception earlier, either prior to hospital discharge or at a three week postnatal care visit (37, 38). The fact that some women do not attend their postnatal care visit suggests the period prior to discharge is a critical window of opportunity to ensure that they get the contraception they need (39, 40). One of the main causes LARC failure is the delay between the choice of method and the time of insertion (15, 16). Early utilization of postpartum contraception is shown to be effective at decreasing rapid repeat pregnancy because the motivation to use a reliable contraceptive method is high (41, 42). Any delay in the provision and receipt of contraception at this time risks waning of that motivation and unintended pregnancy (43).

Counselling and advice

A systematic review on education for contraceptive use by women after childbirth has found the quality of the evidence to be moderate to low. The review concludes that better programme design and implementation could improve the quality of the evidence (44). The inference is that the effectiveness of information and advice as an intervention is dependent on the quality of the information and counselling provided, rather than a question of whether or not counselling and advice should be provided due to a lack of evidence of effectiveness (29, 50). There is a general consensus in the literature that women should receive education and advice on postnatal contraception (28, 45-48). Organisations such as the National Institute for Health and Care Excellence (NICE), the World Health Organization, the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives all advocate providing counselling and advice to women about postnatal contraception (4, 5, 49, 50).

Effectiveness and cost effectiveness of LARCs

There is agreement in the literature that LARCs are the most effective method of contraception, particularly for vulnerable groups (41, 51-53). LARCs appear to have no adverse effect on breastfeeding performance and have been shown to reduce inter-pregnancy intervals and unintended pregnancies (40, 47, 51, 54). Despite the
relatively high rates of expulsion associated with the immediate placement of intrauterine contraceptive devices (IUCDs) post-partum, the continuation rates at 12 months are high (55-57). Expulsion is nevertheless a notable barrier that does need to be appropriately managed in order to prevent unintended pregnancy (58, 59). Even though LARCS are the most effective methods of contraception they are generally underutilised (9, 46, 60). In the UK in 2008-09 only 12% of women aged 16-49 took up LARCs compared 25% who took up the contraceptive pill(2). The evidence suggests that the barriers to use need to be addressed in order to increase their utilisation.

Immediate postpartum insertion of contraceptive implants i.e. before discharge, is associated with higher costs than delayed insertion but is more effective at preventing pregnancies. If however, the resulting costs to the healthcare system and society of unintended pregnancies are taken into consideration then immediate placement of intrauterine devices is considered to be highly cost-effective (23, 61, 62).

**Women’s views**

Little research has been undertaken to assess women’s views on postnatal contraception. What there is largely focusses on how receptive women are to counselling and LARCs rather than on women’s actual experiences of using contraception, what influences contraceptive choices and their decision making processes (45, 63-65). Further research is required to better understand women’s postnatal contraceptive decision-making in order to properly meet their needs.

**Healthcare professionals’ views**

There is a paucity of evidence on the healthcare professionals’ views on postnatal contraception but what there is highlights differing opinions about their role in the delivery of postpartum contraceptive services. A UK study assessing the experiences and views of midwives found that midwives saw their role in providing contraceptive counselling and advice as a minor one and they felt they had little influence over women’s choices. Many did not see it as appropriate or a priority and identified other healthcare professionals as being better placed to deliver postnatal contraceptive care, including social workers, community midwives, general practitioners (GPs) and obstetricians (26). Elsewhere in the literature midwives have embraced their role in delivering contraceptive counselling and advice and are advocating for others to do the same (66-68).

Another UK study that explored the views of midwifery students found that whilst they recognised that giving advice on contraception and family planning was an important part of the midwifery role, many felt that they did not have adequate knowledge and practical training to enable them to advise women safely and with confidence. Most only felt confident enough to give general advice rather than
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Specific advice, and over half of those questioned said that the advice they gave contained some inaccuracies (69).

**Professional training and development**

According to the evidence, GPs, obstetricians and gynaecologists also require additional training. GPs play a pivotal role in providing contraceptive care at the 6 week postnatal check but some are not prioritising it (8). There is some evidence to show that physicians who reported receiving class-room and hands-on training in IUDs were more likely to have provided IUDs (70).

The issue of inadequate training and education is a recurring theme throughout the literature (11, 26, 35, 71). In its guidance on contraceptive services for under 25s, NICE states that, “managers should ensure that doctors, midwives, nurses, pharmacists and other health professionals working in contraceptive services have received the pre-registration training required…They should also have evidence to show that they are maintaining their skills and competencies” (72). It is clear from the literature that there is a discrepancy between the aspiration and the reality of post-partum contraceptive service delivery and receipt.

According to evidence there is a need for postnatal contraceptive care that is largely unmet due to a range of barriers. There is little UK based research and few UK models of service delivery to draw upon so the conclusions in this briefing have been drawn mainly from the available international body of evidence. Further UK-based research is required to inform policy and practice.
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Endnote database matrix showing the UK papers only.

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