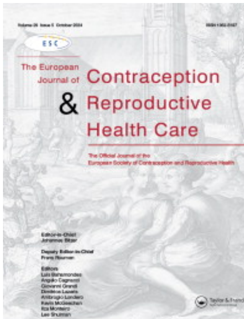

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RESEARCH ARTICLE

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Postpartum contraception provision across Europe: preliminary findings from a multi country survey

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ABSTRACT

Introduction: Looking after a baby and recovering from birth pose barriers to accessing and initiating effective contraception in the postpartum period. Another pregnancy at this time can end in abortion or a short interbirth interval. These are preventable if contraception is provided immediately from maternity settings. Our aim was to survey contraceptive experts across Europe about provision of postpartum contraception (PPC) in their country to develop a greater understanding of availability of and delivery of PPC services within the region.

Materials and Methods: Contraceptive experts across Europe were invited to participate in an anonymous mixed-methods online survey consisting of free text and fixed-response questions focusing on: (1) national guidelines/policy (2) antenatal contraceptive discussion and (3) immediate postpartum provision of methods. Respondents were asked to rate PPC provision in their region and detail perceived facilitators or barriers.

Results: Experts from 28 countries completed the survey. Fifteen (40%) reported their country had national guidelines for PPC provision, 40% reported that some antenatal contraceptive counselling was offered and 51% reported that contraceptive methods were provided in some (43%) or all (8%) maternity settings. Country-level PPC provision was reported as 'poor' or 'very poor' by 54% of respondents. Reported barriers to PPC provision included: cost, lack of policy/government support, awareness and training of maternity staff.

Conclusions: There is significant variation in PPC provision across Europe. Few countries offer antenatal contraceptive counselling or provide contraception from maternity settings. Introduction of supportive PPC policies, funding and training for staff could improve outcomes for mothers and babies.

SHORT CONDENSATION

There is a need for improvement in postpartum contraception provision across Europe, and only a few countries offer women routine antenatal contraceptive counselling or provide contraception directly from maternity settings.

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Postpartum; contraception; policy; Europe

Introduction

Following birth, fertility and sexual activity can resume quickly. In the absence of lactation, ovulation can occur as early as the third week postpartum [1] and there is evidence from several settings that around 50% of women will have resumed sexual activity by six weeks' postpartum [2]. Yet this is a time when women face additional barriers to accessing effective contraception, as the requirements of looking after a baby and recovering from birth impact upon the logistics of making and attending clinic appointments for contraception. Surveys of postnatal women indicate that the vast majority do not plan to become pregnant again in the next 12 months [3] yet data from several countries show that a significant proportion seek abortion in the next year. In the USA it has been reported that 70% of pregnancies that occur in the year after birth are unintended [4]. In a study from Scotland one in 13 abortions were pregnancies conceived within a year of birth [3] and in Sweden, 2.3% of women have an abortion within 2 years of childbirth [5]. In addition, an interval of less than 12 months between birth and next conception has been shown to be an independent risk factor for preterm birth and neonatal death in that pregnancy [6]. These short inter-pregnancy intervals may be more common than previously realised, as one in 13 births in a Scottish study followed this pattern [3]. There is clearly a need to improve access to timely and effective postpartum contraception to help

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women prevent unintended pregnancies and optimise interpregnancy intervals. Guidelines from UK [7], USA [8] and the World Health Organisation [9] support this. Recommendations include the availability of antenatal contraceptive counselling and access to effective methods of contraception in the immediate postpartum period before leaving the maternity unit for those who wish to initiate these. These policies have been successfully implemented in many low-middle income settings [10,11], but systemic and provider-level barriers to wider service implementation are known to exist [12–14].

In Europe, there is contraceptive mapping which tracks country-specific policy and provision of contraceptive supplies and information [15]. Whilst this shows that many parts of Europe have good access to contraception, it highlights some variation in practice and does not feature any measures specifically related to postpartum contraception. The aim of this current study was therefore to determine baseline information on postpartum contraceptive provision across Europe through a representative survey, using the existing professional networks of the European Society of Contraception and Reproductive Health (ESC) and European Board of Obstetricians and Gynaecologists (EBCOG).

Materials and methods

An online quantitative survey was sent to key opinion leaders in contraception across Europe including senior clinicians or clinical academics in obstetrics, gynaecology, sexual health or midwifery. These individuals were identified from the existing professional networks of the ESC and EBCOG. One representative per country was approached to complete the survey. They were invited by an email from the investigators to participate in the survey through an online link. In the case of no response, individuals were emailed a reminder and if unable to complete it were asked to suggest an alternative colleague who could be approached by the survey team and invited to participate. In case of further non-response, the team identified another individual in that country through these networks to send the survey to.

The online survey tool used was Jisc and the survey consisted of questions with mainly fixed-responses but also some with free text comments. It focussed on three key areas: (1) existence of national guidelines/policy documents on PPC (2) availability of routine antenatal contraceptive discussion and (3) immediate postpartum provision of methods from the maternity hospital, in that country. Respondents were also asked to rate what they considered the overall quality of PPC provision was in their country, and any facilitators or barriers to providing this from a maternity hospital after delivery. The final survey comprised ten questions in total and was pilot-tested and adapted prior to formal dissemination.

Descriptive analysis of each question was generated by the online survey tool, including numbers and percentages of total responses to each question. Free text comments were categorised by the research team and grouped into themes.

No ethical approval was required for this survey. The survey was commenced in April 2022 and closed in January 2023.

Results

Of the 46 countries approached, responses were received from 28 (response rate 61%). Respondents were all senior clinicians or academics in obstetrics, gynaecology, sexual and reproductive health or midwifery. The geographical spread of the responses received is shown in Figure 1. Of these, 15 (54%) reported that their country did not have current national guidelines for PPC provision, with 11 (39%) stating they did and two (7%) unsure.

Antenatal discussions about contraception

Antenatal contraceptive discussion was reported to be available on a routine basis in two countries (7%) and on a non-routine or 'opportunistic' basis in 10 (36%). Thirteen (47%) reported no antenatal contraceptive counselling, with the remainder 'unsure'. Where antenatal discussion was provided, it was mostly provided in the third trimester (67%; $n=8$) by either midwives or obstetrician/gynaecologists in most cases (75%; $n=9$). Fifteen survey respondents (54%) reported that pregnant patients were not routinely informed about the risks of short interpregnancy intervals.

Immediate postpartum provision of methods

Thirteen respondents indicated that contraception was available immediately after birth in some (20%; $n=6$) or all (26%; $n=7$) of the maternity hospitals in their country. It was reported as not available by thirteen others (46%), with the remainder unsure (8%; $n=2$). Amongst the eleven countries where national guidelines were reported to exist, immediate PPC provision was available in some or all hospitals in eight (73%). Of those who indicated that immediate PPC was available ($n=13$), it was provided free of charge for all users in 26% of countries ($n=4$), and to some users in another 20% ($n=3$).

When asked specifically about the availability of immediate postpartum long-acting reversible contraceptive (LARC) methods, 57% of respondents ($n=16$) reported that this was not available in their country. Of those who did report offering this ($n=12$), the subdermal implant was the most common LARC available (92%; $n=11$), followed by intra-caesarean postpartum intrauterine device (PPIUD) insertion (58%; $n=7$) and vaginal PPIUD (25%; $n=4$). In these countries, PPIUD was most often provided by obstetrician/gynaecologists (86%) and implant insertion was provided by both obstetrician/gynaecologists (73%) and midwives (36%). Amongst those countries who reported offering immediate contraception ($n=12$), other non-LARC methods were available with the following frequency: progestogen-only pill (54%), sterilisation (39%), barriers methods (32%) and progestogen-only injectables (25%).

Overall rating and free text responses

Respondents were then asked to provide an overall rating of the quality of PPC provision in their country on a nominal 5-point Likert scale, with results shown in Figure 2. Finally, respondents were asked to provide further free texts comments about their experience of PPC provision in their country, including examples of good practice and/or

Key:
Response received
No response received

Figure 1. Map of Europe showing survey distribution and response by country.

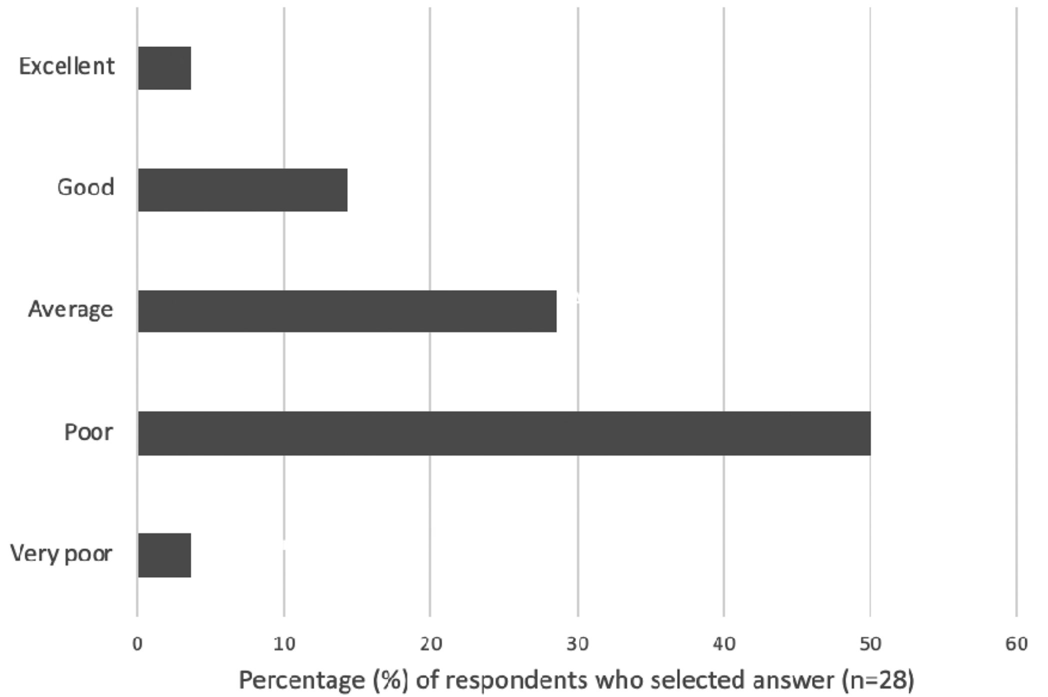

Figure 2. Graph showing overall responses to self-rated opinion of current postpartum contraception provision in own country.

Table 1. Extracts from free text responses about country-level PPC provision.

Examples of perceived facilitators or good practice related to PPC provision
The Government have committed to provision of free contraception, it is slow to get off the ground…that being said, we need to actually be able to give it on-site rather than just provide advice/send them back to GP…we need to make it very easy for people to access
It is very well done from Gynaecologists. Everybody has access, unfortunately patients have to cover the cost, but this is rarely a problem
Every woman who delivers has a 6 week appointment with an OBGYN specialist and her postpartum contraception plan finalised
Post-delivery follow-up visits are important in this regard. They (have) almost 100% attendance since receiving maternity benefits are linked to attendance
Good counselling on contraception at postpartum check-up 6 weeks after delivery
In (my country) vast majority of women come to the follow-up visit to midwives 4-8 weeks after the delivery. Contraception, short interpregnancy interval etc are discussed during this visit….in the case it can be seen…she will not come to (the) post-delivery visit immediate IUD is inserted in the hospital after discharge. Copper IUDs are provided free for women during one year after pregnancy.
Examples of perceived barriers or challenges related to PPC provision
Contraception is not among the priorities in (my country). There is some progress in provision of LARC for vulnerable and disadvantaged women.
Plans to train more midwives to become implant fitters, barriers include funding and time allocation
My hospital used to be a national and international training centre for immediate postpartum IUD insertion however the programme was over and unfortunately it did not become routine practice afterwards. Subdermal implants are very expensive but if the woman purchases the implant it is inserted at my hospital free of charge
Challenge in (my country) is providing immediate postpartum IUD and talking about contraception antepartum
Budgetary/commissioning lines prevent maternity services from taking ownership of the service and funding appropriately…failed due to commissioning constraints, junior leadership and transient workforce
Most obstetricians are probably not too conscious about contraceptive provision in the immediate postpartum period here. Not many of our local women would resume sex shortly after delivery. Breast feeding rate is very high nowadays and that confers a kind of 'contraception' anyway. We do educate women routinely on contraception in the postnatal ward but seldom do women request a supply…I agree this is an area that we are weak in and certainly much more work should be done.
A very high number of women in (my country) breastfeed and assume that they do not immediately need postpartum contraception. No women are aware that they can ovulate within a few weeks after birth, if they do not use contraception.
Services remain inconsistent between health boards with low numbers of midwives trained to administer LARC.
Education is needed. Both physician and patients.

challenges or barriers encountered (if any). Eight respondents (29%) indicated that they were aware of plans to develop or expand PPC provision in their country. Where further information was provided, these plans mainly centred around training initiatives and/or guideline development. Extracts from the free text responses are shown in Table 1.

A postnatal check-up visit was identified as a useful time for discussion and provision of postpartum contraception by some respondents ($n=4$). Of those who commented, these visits were noted to be provided by specialists (midwives or obstetrician/gynaecologists) and in some cases, attendance was linked to receipt of maternity benefit payments. In one country response, provision of contraception for free was also felt to be a facilitator to PPC provision.

Several challenges were identified in relation to PPC provision. The main themes were: lack of awareness and/or misconceptions amongst women; lack of availability of maternity staff with training in contraception (particularly in subdermal implant and intrauterine device insertion); no antenatal discussion about contraception; financial barriers either related to patient-funded contraception or service-level commissioning.

Discussion

Findings and interpretation

This study showed that according to our respondents, in more than half of the European countries surveyed antenatal contraceptive counselling and provision of contraception available immediately after delivery from the maternity hospital is not considered 'routine'. A similar proportion of countries did not have national guidelines around postpartum contraception. Provision of long-acting contraceptive methods immediately postpartum was even more limited, with only around 40% countries reportedly providing postpartum implant insertion, and 25% able to provide immediate postpartum intrauterine device insertion from within the maternity setting. According to the rating of respondents, postpartum contraceptive care was felt to be just average or poor in three quarters of the European countries. The reported barriers to provision of contraception across Europe included an absence of government policy in this area, lack of funding to provide contraception from the hospital and lack of trained maternity staff (especially those able to provide LARC method insertion immediately postpartum), lack of routine antenatal contraceptive discussion and limited public awareness. Facilitators to provision included supportive policies on provision of free contraception and in a small number of countries, the ability to offer a routine postnatal check with a specialist.

Results in the context of what is known

There is wide-ranging literature on postpartum contraception provision [10], and much of it is from low- and middle-income settings where the barriers to accessing contraception after childbirth may be especially challenging. However, there is growing recognition that in high income settings there are also missed opportunities during the antenatal and postnatal period when a woman is in contact with a wide range of healthcare providers to discuss future fertility aspirations and contraception, and to provide her with her chosen method of contraception [3]. Like the information available about general contraception provision [15], there appears to be wide variation in practice across Europe around PPC, with most countries recognising a need for improvement in this area.

Postnatal visits were highlighted as an opportunity to support PPC provision, but existing literature indicates that a significant proportion of women do not attend these or may already be sexually active and at risk of pregnancy [16]. Furthermore, women find it highly acceptable to discuss their future fertility plans and contraception during pregnancy, and routine antenatal contraceptive counselling has been shown to be feasible to implement [17]. This survey indicated under-utilisation of immediate postpartum LARC provision, despite considerable evidence supporting the safety and efficacy of providing these methods at this time.

Simplified access to these methods in the postpartum setting may have the potential to prevent more unintended pregnancies and short intervals between births. There is data from the USA that strongly suggests that when LARC is made available at no cost from maternity hospitals, it is associated with improved subsequent birth outcomes such as a reduction in preterm birth [18]. Access to immediate postpartum IUD insertion at the time of birth has been shown to be highly acceptable to women in high-income settings [19]. Furthermore, despite the higher reported expulsion rate of immediate PPIUD insertion, it has been shown to remain a cost-effective intervention [20]. The barriers to providing immediate postpartum LARC identified in this survey, particularly around staff training, are consistent with those highlighted elsewhere [21,22].

Clinical implications

Contraception is a low-cost technology, yet there is significant variation in PPC provision across Europe. Few countries offer women routine antenatal contraceptive counselling or provide contraception from the maternity setting. Reproductive health experts across Europe need to champion their policy makers on the benefits of PPC for women, babies and society. We need the introduction of supportive PPC policies across Europe, funding for PPC services and tailored education for staff to provide this from maternity services. This should include practical training in techniques such as immediate PPIUD insertion. We need maternity guidelines to provide recommendations on provision of antenatal contraceptive counselling, including how and when these discussions should take place. This should be partnered with quality accessible information on postpartum contraception choices for women antenatally, both at individual level and through public health campaigns, so that they are empowered and informed to plan their future contraceptive needs.

Research implications

This study demonstrates the variation in practice that exist across Europe, and the opportunities for further service development and research. In the next phase of this work, we plan to conduct an analytical hierarchical mapping process to gain further detail about how individual countries perform with respect to agreed parameters of ‘successful’ postpartum contraceptive service delivery. This will allow us to develop a PPC-specific European atlas as a potentially useful tool in helping to influence clinicians, researchers, and policymakers in the future, and may serve as a catalyst to increased PPC availability across Europe. Furthermore, we plan to develop an international PPC consortium to further share and learn from global experiences.

Strengths and limitations

This study is the first to report on provision of PPC across Europe and used the networks of ESC and EBCOG to identify country experts to respond on this subject matter. It provides a starting point to build a picture of PPC availability on a larger scale than just individual regions or countries, where previous studies have mainly focused. However, given that the country responses were the views of a single individual in that country it is possible that these may not always accurately reflect the situation. In addition, there can be variation in service provision within a country and this survey design was unable to account for that. Furthermore, responses were not received for every country and thus the findings may not be wholly representative. As the survey questions were mostly fixed responses, these also did not allow for further detailed exploration of the underlying justifications, complexities or nuances involved. Additional qualitative and quantitative research would be important to better understand these.

Conclusions

There is significant variation in PPC provision across Europe and few countries offer women antenatal contraceptive counselling or provide contraception from the maternity setting. Introduction of supportive PPC policies, funding and training for staff could improve the timely provision and uptake of effective contraception, and ultimately improve outcomes for mothers and babies across Europe.

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Disclosure statement

No potential conflict of interest was reported by the author(s).

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Data availability

The data that support the findings of this study are available from the corresponding author MC upon reasonable request.

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