General practitioners' views and experiences of postpartum contraception counselling and provision: a qualitative–descriptive study

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The known: Antenatal and postnatal contraception counselling increases the uptake of contraception, reducing the risk of unintended pregnancy and short inter-pregnancy intervals.

The new: General practitioners can discuss contraception with mothers at postnatal checks, but they are often restricted by the time available, limited collaboration with other maternity care providers, and the absence of guidelines for the postnatal check and postpartum contraception care.

The implications: Increasing the provision of postpartum contraception care by general practitioners requires greater access to education and training, appropriate remuneration for contraception procedures, more multidisciplinary collaboration, and national postpartum contraception guidelines.

Abstract

Objectives: To explore Australian general practitioners' views and experiences of undertaking postpartum contraception counselling and provision during the 6–8-week postnatal check.

Study design: Qualitative–descriptive study; semi-structured online interviews.

Participants, setting: General practitioners who provide postnatal care in Australian primary health care, recruited using purposive, convenience, and snowball methods, 16 June – 6 July 2023.

Main outcome measures: Views and experiences of postpartum contraception counselling and provision.

Results: Twenty-three general practitioners from six states were interviewed; the mean interview time was 30 minutes (range, 21–47 minutes), twenty-two participants were women, and twenty-one worked in metropolitan areas. All participants provide postnatal checks and had the training and facilities needed for providing contraceptive implant insertions. Twelve participants had training in intrauterine device (IUD) insertion, and twenty-one worked in practices with facilities for IUD insertions. Three themes were constructed: views and preferences regarding postnatal contraception counselling; postpartum provision of long-acting reversible contraception (LARC); and opportunities for improving postpartum contraception care in general practice. While most participants recommended LARC methods at postnatal checks, only twelve were trained to insert IUDs. Time constraints, limited access to training, limited financial support, and the lack of guidelines for postnatal checks and contraception care were seen as impeding postpartum contraception counselling. Participants highlighted the importance of access to education and training, appropriate remuneration for general practitioners, multidisciplinary collaboration among health professionals, the inclusion of practice nurses, and raising awareness among mothers of the importance of postnatal checks and postpartum contraception care.

Conclusion: General practitioners are well placed to facilitate discussions about contraception with women who have recently given birth. Postpartum contraception care in general practice could be improved by better access to contraception training, appropriate remuneration for contraception procedures, greater multidisciplinary collaboration, and national postnatal check and postpartum contraception guidelines.

A 2016 Australian survey found that 40% of pregnancies are unintended.[1] A more recent study found that 31% of unintended pregnancies in Australia end in abortion.[2] Contraception during the postpartum period is effective for preventing unintended pregnancies and short inter-pregnancy intervals (less than 18 months since the preceding birth), facilitating pregnancy planning and spacing.[3,4] Short inter-pregnancy intervals are associated with adverse outcomes such as preterm birth, developmental delays, and fetal or neonatal death.[5]

Routine 6–8-week postnatal checks are usually undertaken by general practitioners.[6] The content of postnatal checks varies between general practitioners because the immediate needs of the mother are the priority, and because there is no Australian guideline for postnatal checks. Postpartum contraception counselling should be an essential aspect of the postnatal check, as it provides women with comprehensive contraception information, enabling them to make informed decisions.[3,7] However, such counselling is not always provided.[8,9]

As the postpartum contraception services provided by general practitioners in Australia have not been investigated in detail, we explored general practitioners' views on and experiences of postpartum contraception counselling and provision during the 6–8-week postnatal check.

Methods

General practitioners were eligible to participate in our qualitative–descriptive study if they were registered with the Australian Health Practitioner Regulation Agency (AHPRA), currently practising in Australia, and provided postnatal care. We report our study according to the Consolidated Criteria for Reporting Qualitative Studies.[10]

Recruitment

We used purposive, convenience, and snowball methods to recruit general practitioners, including via social media networks (Facebook, Instagram, X, Australian Contraception and Abortion Primary Care Practitioner Support [AusCAPPS] network), organisational newsletters, and professional contacts. General practitioners who contacted author JP for study details were emailed an explanatory statement (Supporting Information, part 1). General practitioners who confirmed their willingness to participate in an interview were verified using

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the AHPRA registry to ensure they were registered in Australia. Recruitment ended when we deemed information power to have been reached, based on the aim of the study.[11]

Data collection

The semi-structured interview guide (Supporting Information, part 2) was informed by the findings of a literature review and the authors' experience in women's health and primary care research. It was adjusted after a pilot interview with a general practitioner and feedback from the research team. Author JP conducted all interviews during 16 June – 6 July 2023 via Zoom. Verbal consent was obtained from each participant before the interview. Interviews were audio-recorded (with the verbal consent of the participant) and transcribed verbatim. Conversational rapport with participants was developed prior to interviews. Written notes were made during interviews, including about interview duration, demographic characteristics of the participant, and additional observations regarding the interview. Pseudonyms were assigned to participants to ensure anonymity, and all identifiable information was stored in separate password-encrypted files. Member checking of transcripts was not conducted because of time constraints. Each participant received a $150 gift card for their time.

Data analysis

We applied reflexive thematic analysis[12] to identify and synthesise key themes over six study phases. Author JP led the data analysis in collaboration with the research team to verify, refine, and improve the analysis. Data familiarisation (phase 1) included data transcription, quality checking, and reviewing transcripts. Transcripts were then imported into NVivo12 and initial codes and sub-codes generated (phase 2). Codes were collated under potential themes (phase 3) and discussed with the research team (phase 4) (Supporting Information, part 3). Themes were then refined and named (phase 5), and the final report (Biomedical Sciences Honours degree thesis) was produced (phase 6).

Ethics approval

The Monash University Human Research Ethics Committee approved the study (38294).

Results

Twenty-three general practitioners from six Australian states were interviewed; the mean interview time was 30 minutes (range, 21–47 minutes), twenty-two participants were women, and twenty-one were located in metropolitan areas. All participants provided postnatal checks and had the training and facilities needed for inserting contraceptive implants. Twelve participants had training in intrauterine device (IUD) insertion, and twenty-one worked in practices with facilities for IUD insertion (Box 1).

Three themes were constructed from the interview data: views and preferences regarding postnatal contraception counselling; postpartum provision of long-acting reversible contraception (LARC); and opportunities for improving postpartum contraception care in general practice. Sample quotes for each theme are included in Box 2.

Views and preferences regarding postnatal contraception counselling

All participants aimed to discuss contraception at postnatal checks, but their views on the best time to initiate contraception

1 Demographic characteristics of the 23 general practitioners who were interviewed for our study

Characteristics	Number
Gender	
Women	22
Non-binary	1
State	
Victoria	10
New South Wales	4
Western Australia	3
South Australia	3
Queensland	2
Tasmania	1
Privately owned practices	23
Remoteness of practice	
Metropolitan (MMM1)	21
Rural (MMM2–5)	2
Country of general practitioner training	
Australia	21
Ireland or Scotland	2
Non-general practice specialty training	
Gynaecology and obstetrics	2
Antenatal care	1
None	
Additional training in sexual and reproductive health	
Yes	16
No	7
General practice experience (years)	
0–4	8
5–9	7
10–14	4
15–20	4
General practice billing type	
Mixed billing	20
Private billing	2
Bulk billing	1
Trained in IUD provision	
Yes	12
No	11
Facilities and equipment to provide IUD insertion	
Yes	21
No	2
IUDs provided per month	
0	1
1–5	5
6–10	4
11–15	1
16–20	1

Continues

Characteristics	Number
Trained in implant provision	23
Facilities to provide implant insertion	23
Implants provided per month	
0	1
1–4	18
5–8	2
9–12	2

IUD = intrauterine device; MMM = Modified Monash Model.[13] ◆

discussions varied. Some commented that raising contraception during the postnatal check was premature, as women were usually unreceptive at this point, and suggested that it should be discussed at a later appointment, such as a 3-month check. Participants described women being "caught off guard" (GP3), in "disbelief and laughing" (GP2), or "shocked" (GP10), as they had recently given birth and had not considered resuming sexual intercourse. Other participants felt that contraception discussions should begin earlier, during antenatal appointments or in hospital after giving birth, as this could improve the woman's ability to absorb information and increase their receptiveness for the idea when raised at a later visit.

Participants mentioned that opportunities to discuss contraception before the postnatal check were often limited, as most pregnant women received antenatal care from midwives or obstetricians. GP23 said, "I don't see a lot of pregnant people past the first trimester… I would hope that [contraception] would be something that was discussed like by the obstetric team." However, most participants felt that contraception was something they could discuss during the postnatal period, particularly as they generally had an ongoing relationship with the women even if they had not provided their antenatal care. They noted, however, that their priorities for the postnatal check often differed from those of the mothers, who placed greater emphasis on the well-being of their baby and current problems, whereas general practitioners wanted to also discuss the mother's mental and physical health and their future, including family planning. Inadequate time during the postnatal check was raised by all participants as a barrier to providing contraception counselling.

The participants did not know of any postpartum contraception guideline they could consult about postnatal checks or postpartum contraception counselling. Most relied on guides that they or their practices had developed, typically based on hospital guidelines and personal clinical experience. Participants felt that a national guideline could help ensure that all general practitioners covered essential elements of postnatal care, reduce diversions from key topics, and enhance practitioners' confidence when providing postnatal services.

Postpartum provision of long-acting reversible contraception

Most participants recommended IUDs and implants as the most reliable and convenient contraceptive methods, followed by shorter acting contraceptive methods and lactational amenorrhea. However, although all were trained in implant insertion, only twelve participants had been trained in IUD insertion. Participants who did not have IUD training did not feel they needed to learn the procedure because the demand for

2 General practitioner-centred themes and sample quotes from interviews

Theme/subtheme	Quote
Views and preferences related to postnatal contraception counselling	
Optimal time for contraception counselling	I often discuss contraception postnatally but if I had more time antenatally, that's when I would prefer to discuss it because I reckon there's more information uptake antenatally. (GP8)
Barriers to postpartum contraception counselling in postnatal checks	If there's a lot of competing demands in the visit… rather than focusing on her needs, she's concentrating more on potentially the baby's needs. (GP22) There is the doctor's agenda, and there is a patient's agenda… and it doesn't always match but I think it's our job to kind of just to bring it to the common ground. (GP16) At one of the religious hospitals where [I worked] you weren't allowed to discuss anything like [contraception]. (GP23)
Providing postpartum long-acting reversible contraception	
Preferences for long-acting reversible contraception	I tend to try and recommend something like an Implanon or IUD if they definitely not… planning pregnancy within the next 12 months. (GP15)
Challenges to providing long-acting reversible contraception	I guess the biggest [barrier] at the moment is not being able to fit IUDs, or having provision to do that in the clinic here (GP15) I have nurses who will help me but they're not confident in what they're doing, and I have to direct it a little bit, which just makes the process a little bit more difficult, and also more time-consuming (GP14) If they want an IUD, it's going to be multiple appointments, unfortunately, because they're going to need that assessment with the scripts and then to come back and have the insertion. (GP9)
Facilitators of contraception provision	I tend to try and recommend something like an Implanon or IUD if they definitely not… planning pregnancy within the next 12 months or have any objections to that just because it's a bit more reliable. (GP15) I think a facilitator and enabler for me is the fact that I can offer both Implanon and IUD insertion. (GP7)
Opportunities for optimising postpartum contraception care in general practice	
Improving access to education and training	[Training] needs to be directed to GPs and in sort of a bitesize, because GPs don't have a lot of time to do like a 6-hour module. (GP14)
Incentives for providing contraception care	Providing a Medicare item number for postpartum care would be something that would then probably incentivise more people to provide it. (GP18)

Continues

2 Continued

Theme/subtheme	Quote
Multidisciplinary collaboration	I think even doing joint educational updates would be really handy because I feel like in all of those professions there are people who are right up to date, and there are people who have fallen a little behind and that's not your own fault. It's just hard to be up to date on everything. (GP7)
	I will usually also refer to the nurse just so that [the women] can have a bit more time… and [the nurse can] actually take them through each of those [contraceptive] options as required. (GP13)
Increasing women's understanding of the importance of postpartum care	There's a lot of myths, there's a lot of misconceptions about contraception, and I think, just putting it out there, the options that are available, their effectiveness… can be quite helpful for patients, and knowing that they can go to their general practitioner to seek advice and to discuss their options. (GP13)

IUD = intrauterine device. ◆

IUDs among the new mothers they saw was low, they did not have the time or interest to undertake training, or they could refer women to other trained practitioners for the procedure.

Many participants discussed barriers to IUD use by women after giving birth, including long waiting times and the need for several appointments. Some participants voiced concerns about the risk of women being lost to follow-up after an insertion because of factors such as "juggling the baby and potentially other family members" (GP19). As IUDs are not readily accessible to all women, participants highlighted the importance of initiating a bridging contraception option, such as oral short-acting contraception, to ensure coverage for all mothers.

The shortage of practice nurses equipped to support or provide IUDs and implant insertions was mentioned by some participants as a barrier to providing postpartum LARC. Participants suggested that better using practice nurses could help ensure efficient postnatal appointments and could increase access to and the uptake of contraception.

Opportunities for improving postpartum contraception care in general practice

Participants noted that it is often difficult to attend contraception education and training, including in LARC counselling and insertion, because of the time commitment required. General practitioners who had undergone LARC training or had considered seeking training emphasised other barriers, including long waiting times because of the limited availability of qualified instructors, high course costs, and costs associated with travel and unpaid leave. Delivering educational programs in a concise and efficient manner as online modules was raised as an important strategy for improving access to training.

Participants also suggested that monetary incentives, such as Medicare rebates for postnatal checks and contraception services, could motivate general practitioners to undergo training and provide additional services. Compliance with current rules and regulations associated with claiming specific Medicare items for LARC services was noted as a barrier to service provision. Increasing rebates would additionally provide general practitioners the ability to offer lower cost services, which most felt was not currently viable: "[general practitioners] are altruistic but… we need to pay our bills" (GP18).

Multidisciplinary collaboration among health care professionals engaged in antenatal or postnatal care was raised by participants as an important aspect of continuity of care for mothers. They suggested that midwives or maternal and child health nurses initiating discussions of postpartum contraception prior to the six-week postnatal check could enhance the effectiveness of related conversations during the postnatal check. Several participants also noted the advantages of multidisciplinary educational opportunities, such as seminars or discussion groups, for facilitating conversations about contraception in different clinician groups; they felt this would enable health professionals to share knowledge, support one another, and stay informed about the latest recommendations and practices in the field.

Finally, participants emphasised the need to raise awareness among women of the importance of postpartum checks. While many mothers are aware they need to schedule six-week appointments for their baby, they may not do the same for themselves or to give it priority. Participants suggested that women's understanding of the importance of postpartum care could be improved by online platforms, such as social media, as well as by discussions during antenatal classes or workshops.

Discussion

All general practitioners in our study aimed to mention contraception at postnatal checks. However, a number of barriers to postpartum contraception counselling and provision were identified, including time constraints, limited access to training, limited financial support, and the absence of guidelines for postnatal checks and postpartum contraception care. Participants highlighted the importance of access to education and training, appropriate remuneration, multidisciplinary collaboration among health professionals, and the inclusion of practice nurses in postpartum care to better facilitate access to postpartum contraception discussions and uptake in general practice.

The lack of guidelines for postnatal checks and contraception discussions was a concern for participants. Australian general practice registrars have limited exposure to postpartum care, limiting their experience.[14] Many general practitioners in our study said they developed their own guides based on personal clinical experience and information gathered from various sources. Comprehensive guidelines for postnatal checks in general practice, including postpartum contraception recommendations, would ensure that all women receive consistent and high quality care during this period.

Most participants in our study recommended LARC methods during postnatal checks. However, clinical and practitioner-related barriers, including lack of knowledge and training for clinicians, limited access to services and the need for women to attend multiple appointments, and the costs for clinicians and women all limit the effective provision of LARC

services.[15,16] Easily accessible IUD training and rapid referral pathways are potential facilitators of contraception uptake.[17] Additional strategies for improving access include appropriate remuneration for contraception procedures, which would also reduce the costs for women, and new models of collaborative care bey general practitioners and practice nurses.[18] Incentives to provide postnatal checks and contraception services could encourage more general practitioners to acquire the required knowledge and skills.

Although postpartum contraception care is a collective maternal health professional responsibility,[19] it is typically left to general practitioners during postnatal checks.[20] Shared care models of health care, in which multidisciplinary teams support the provision of postpartum contraception, would support continuity of care and assist women with informed contraception choices.

Limitations

Most participants in our study were women who resided in metropolitan Australia. Surveying male general practitioners and general practitioners in rural and remote areas would capture diverse experiences of specific aspects of postpartum contraception care. Further, we did not ask about the involvement of participants in shared care models, which would have provided context for our findings. The barriers to postpartum contraception service provision we identified should be further investigated, including with respect to educational programs, evidence-based guidelines, service remuneration, and innovative care models.

Conclusion

General practitioners are well placed to facilitate discussions about contraception and access to contraception with women who have recently given birth. Providing postpartum contraception care in general practice could be optimised by improved access to contraception education and training for general practitioners, appropriate remuneration for contraception procedures, enhanced multidisciplinary collaboration, national postnatal check and postpartum contraception guidelines, and the consideration of new models of collaborative care by general practitioners and practice nurses.

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Supporting Information

Additional Supporting Information is included with the online version of this article.