Perspectives of obstetricians and midwives on the provision of immediate postpartum intrauterine devices: a qualitative service evaluation

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ABSTRACT

Background Immediate postpartum intrauterine device (PPIUD) insertion is safe and effective but largely unavailable in Europe. Data on maternity staff views on the provision and implementation of PPIUD services are limited. The objective of this qualitative evaluation was to explore the views and experiences of obstetricians and midwives providing PPIUD within a UK maternity setting, in order to identify areas for improvement and inform service provision in other areas.

Methods Qualitative health services research within two public maternity hospitals in Lothian (Edinburgh and surrounding region), UK. Interviews with 30 maternity staff (obstetricians n=8; midwives n=22) involved in PPIUD provision. Data were analysed thematically.

Results Maternity staff were positive about the benefits of PPIUD for women. Midwives reported initial concerns about PPIUD safety, and the impact on workload; these views shifted following training, and as PPIUD was embedded into practice. Having a large pool of PPIUD-trained staff was identified as an important factor in successful service implementation. Having PPIUD ‘champions’ was important to address staff concerns, encourage training uptake, and advocate for the service to ensure continued resourcing.

Conclusions PPIUD in maternity services can help address unmet need for effective contraception in the immediate postpartum period. We emphasise the importance of widespread engagement around PPIUD among all healthcare professionals involved in the care of women, to ensure staff are informed and supported. Clinical champions and leaders play a key role in amplifying the benefits of PPIUD, and advancing organisational learning.

INTRODUCTION

Short inter-pregnancy intervals (<12 months) are linked to poor outcomes for mother and child.1 Research evidence suggests that conception within 1 year of childbirth is common, with one UK study finding that around 1 in 13 women giving birth or presenting for abortion had conceived within the last 12 months.2 The importance of providing women with immediate postpartum contraception, including long-acting reversible contraception (LARC), is supported by evidence that demonstrates it can reduce the incidence of short inter-pregnancy intervals and unintended pregnancy.3 4 The COVID-19 pandemic has underscored the benefits of provision of immediate...
postpartum contraception; disruptions in access to contraception in the community, and reductions in face-to-face appointments, demonstrate the importance of encounters with maternity staff who can provide effective postpartum contraception.5

In the UK, contraception and maternity care are provided free-of-charge by the National Health Service (NHS); however, challenges with integrating services persist, particularly for contraceptive methods such as intrauterine devices (IUDs) that require insertion by trained healthcare providers. Women choosing an IUD typically have the device inserted no sooner than 4 weeks after giving birth, and the requirement to attend a clinic for insertion creates a potential barrier to access.6 The option of IUD insertion within 48 hours of childbirth – immediate postpartum intrauterine device (PPIUD) insertion – offers women an alternative, and has consistently been shown to be a safe7–9 and convenient option.10

In July 2015, PPIUD at caesarean delivery was introduced across NHS Lothian maternity services (Edinburgh and surrounding region), UK. In this region, there were 8350 births in the year 2018/2019.11 Antenatally, all women receive contraceptive counselling from a community midwife, including the option to receive a copper IUD or levonorgestrel intrauterine system (IUS) immediately after vaginal or planned caesarean birth. Vaginal PPIUD insertion, performed by both midwives and obstetricians, was introduced in 2017.12 The feasibility and acceptability to women of providing PPIUD, and the process of service implementation, are reported elsewhere.10 12–14

This article reports on a qualitative evaluation exploring the perspectives of maternity staff involved in providing PPIUD, with the aim of informing PPIUD provision in maternity services in the UK and other countries.

METHODS
The qualitative evaluation explored two key research questions: What are the views of maternity staff towards PPIUD, and their role in its implementation? What areas for service improvement do staff identify in relation to PPIUD service provision?

Between August 2017 and October 2018 we recruited 30 maternity staff (midwives and obstetricians) from the two public maternity hospitals in NHS Lothian. A phased approach to recruitment was used to capture staff views at different points during PPIUD implementation. We purposively sampled to provide representation across occupational groups and grades. Maternity staff involved in PPIUD were provided with information on the study, and invited to participate in an interview using an ‘opt-in’ approach.

Sixteen individual interviews were conducted. Staff were offered the option of a group interview where this was more convenient; 14 staff participated in three group interviews. Interviews were conducted by one of the authors (NB), a female qualitative researcher (not clinically trained). A topic guide was used, which covered: the role of staff in, and experience of, PPIUD provision; perceived barriers and facilitators to PPIUD implementation within maternity services; and areas for service improvement (online supplemental table S1). Interviews were conducted in the participant’s workplace (n=26) or by telephone (n=4), lasted on average 50 min, and were digitally recorded and transcribed.

The qualitative data were analysed thematically,15 16 by two of the authors (NB and JH), both medical sociologists with extensive experience of conducting research on sexual and reproductive health. Transcripts were read repeatedly, following which a coding scheme was developed that encapsulated the original research questions and issues identified through engagement with the data. NVivo Qualitative Data Analysis Software17 was used to facilitate data coding and retrieval. Data were then cross-compared to identify recurrent themes. These two authors met frequently to discuss findings and compare analytic interpretations. They also reflected on how their ‘non-clinical status’ influenced interviews and analysis; checking language and understandings during interviews, and discussing interpretations with the wider study team (all healthcare providers).

The study received favourable ethical opinion from the Usher Research Ethics Group at the University of Edinburgh (12 July 2017). Consent for study participation was obtained prior to interview.

Patient and public involvement
A steering group, including patient and public involvement (PPI) representatives, provided guidance on both the study and PPIUD service development. A summary of the research findings was offered to all participants.

RESULTS
The final sample comprised 30 maternity staff (22 midwives and 8 obstetricians) outlined in table 1. We present three thematic areas from our analysis: (1) views on the benefits of PPIUD; (2) staff experiences

| Occupational group               | n     |
|----------------------------------|-------|
| Junior midwives                  | 14    |
| Senior midwife                   | 8     |
| Trainee obstetrician             | 5     |
| Consultant obstetrician          | 3     |
| Total                            | 30    |

*Includes newly qualified midwives and junior charge midwives.
†Includes midwives working at a more senior level (eg, advanced practitioners, midwives managing a team, midwives in leadership and management roles, etc.).
of implementing and providing PPIUD; and (3) views on areas for service improvement.

**Views on the benefits of PPIUD**

**Benefits of PPIUD for women**

A primary motivation for staff in supporting PPIUD provision were the benefits to women in enabling them to leave hospital with the knowledge that they had effective ‘contraceptive cover’. IUDs were understood to be highly effective, reliable and ‘non-user dependent’. Furthermore, staff noted that many women were anxious about ‘normal’ (interval) IUD insertion, and were less focused on contraception in the postnatal period. PPIUD at the time of birth was perceived as helping to overcome concerns around pain at interval insertion, and reduce the need for additional appointments. As such, PPIUD was understood to remove barriers to uptake of effective contraception.

**Benefits of PPIUD for health service provision**

Staff noted several benefits of PPIUD related to health service provision. PPIUD was understood to create opportunities for service improvements by reducing the ‘burden’ of missed postnatal appointments. PPIUD was also described as having public health benefits; use of effective contraception was understood to play a critical role in addressing pregnancy spacing and reducing abortion rates. Lastly, staff noted that regardless of whether women opted for PPIUD, providing the option encouraged conversations around topics such as pregnancy spacing, resuming sex and return of fertility, and thus raised awareness of the benefits of postnatal contraception (**table 2**).

**Staff views and experiences of providing PPIUD**

Expanding staff skills and supporting holistic maternity care

The ability to insert PPIUD was understood by staff, especially midwives, as expanding their skill set and contributing to their ongoing professional development. Midwives also highlighted PPIUD as enhancing their satisfaction in providing a holistic service, and caring for women through their maternity journey: labour, birth and provision of postpartum contraception. Nevertheless, some midwives argued that PPIUD training may not be appropriate for all (ie, those nearing retirement, or newly qualified).

**Role and workload extension**

Understanding of professional roles and expectations around workload shaped staff views on PPIUD provision. In the early stages of implementation, midwives articulated unease around the issue of ‘role extension’; specifically, taking on responsibility for a procedure typically undertaken by obstetricians. This was often linked to concerns around increased workload, and that PPIUD would add to midwives’ already busy workload, which could undermine the care provided to women. These concerns were mitigated for some, as they began to practise PPIUD insertion. However, midwives noted that these views continued to circulate

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**Table 2**

| Thematic areas | Verbatim quotes – views on the benefits of postpartum intrauterine device (PPIUD) insertion |
|----------------|-------------------------------------------------------------------------------------------|
| **Benefits of PPIUD for women** | "...the benefits of [PPIUD] is that it's much more convenient for women to have it inserted just after they've delivered, especially when you've got a young baby going home with as well." [Senior Midwife] |
| | "I think it's ideal because, you know, the sort of fit and forget idea about it, you know, postnatal women have got so much more on their mind than contraception, and as I said, like, they'll be busy after having the baby and it's one more thing to remember to go and get fitted, whereas if you can do that all at the time then they're kinda covered leaving the hospital." | [Midwife Group] |
| | "...it's non-user dependent, you're going to have better efficacy. If they go away on condoms or the pill they've got a one in eight chance of being back within the year, of being pregnant, often that's an unplanned pregnancy and we know that interpregnancy intervals should ideally be at least a year in terms of impact on the neonatal and maternal health. So I just think, if you take away the user dependency of it, that's a good thing, and equally it's about giving them choice." | [Senior Midwife] |
| | "...from a medical point of view, from my point of view it's extremely satisfying that somebody will come in, have their baby, get this put in and away they go; it feels efficient." | [Consultant Obstetrician] |
| | "Women are very anxious about having a coil put in, they think it's going to hurt, it's going to be sore, so actually the benefit of when, particularly if someone's got an epidural in, they've literally just had a baby and that's a wee small time to insert it and it shouldn't be sore." | [Consultant Obstetrician] |

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GP, general practitioner; MW, midwife; PPIUD, postpartum intrauterine device.
and, for some, acted as a barrier to engaging in PPIUD training and delivery.

Concerns about potential drawbacks of PPIUD
Concerns around potential drawbacks (and risks) of PPIUD circulating among staff were identified during the pre-implementation phase and early stages of service introduction. These included: women’s experience of pain during vaginal PPIUD; potential complications of IUD insertion; and the impact of immediate insertion at vaginal birth on mother–baby bonding and breastfeeding initiation. Extant research on PPIUD was presented during staff training sessions, and staff reported this as going some way towards addressing such concerns. Furthermore, the clinical research team supported ‘feedback loops’ to share experiences of PPIUD practice as implementation progressed. As PPIUD became established, staff reported observing benefits to women and midwives noted that widespread concerns around PPIUD insertion pain, and impact on breastfeeding, did not materialise. Indeed, midwives reported no negative impact on the women’s birth experience, and noted that women tended to experience less pain than a ‘normal’ insertion. Furthermore, staff described the advantages of PPIUD insertion taking place soon after birth as this reduced logistical challenges, such as finding a suitable space and equipment for insertion. Taken together, this led to a shift towards increasingly positive views on the benefits of PPIUD over the course of the evaluation.

Some staff expressed concerns about expulsion rates (following vaginal PPIUD) as a potential disadvantage of immediate IUD insertion, and a barrier to uptake of PPIUD in the long term. Obstetricians noted that the benefits of PPIUD were contingent on expulsions/ partial expulsions being identified at follow-up review, and a new device inserted (or alternative contraception provided). They reflected on potential challenges for women in accessing follow-up review at their general practitioner (GP) practice in the postpartum period. Similarly, midwives reported emphasising the importance of attending for follow-up during discussions with women (at the time of insertion) as a way of addressing concerns around expulsion (table 3).

Staff views on areas for PPIUD service improvement
Leading the ‘culture shift’
The extent to which staff ‘bought into’ the rationale for PPIUD in the context of maternity care was reported by participants as being critical to their engagement in service delivery. Staff emphasised the importance of leadership by senior obstetricians and midwives in championing PPIUD, and leading a ‘culture shift’ in which PPIUD was prioritised within maternity care.

Reaching a ‘critical mass’ of PPIUD-trained staff
Having a pool of PPIUD-trained staff large enough (relative to the size of the maternity unit) to facilitate full service cover for all women wanting PPIUD was identified by midwives and obstetricians as an important factor in successful service implementation. Staff articulated their belief that once a ‘critical mass’ of trained staff were available, challenges to service delivery, such as delays to insertion after vaginal birth, would be reduced, if not eliminated.

PPIUD information provision and support
Staff, particularly midwives, reported encountering some women who had not discussed, or been offered, PPIUD during the antenatal period; they emphasised the importance of raising awareness of PPIUD antenatally. Staff noted that women often share experiences of pregnancy and birth and so addressing misconceptions about IUDs and insertion could help address barriers to uptake.

Staff, particularly obstetricians providing PPIUD at caesarean section, emphasised the need for consistent post-insertion information provision and support (ie, what to expect after insertion, contraceptive cover, and attending for follow-up review). Without this, staff noted the risk that IUD expulsion would not be identified and women could experience unintended pregnancy. To mitigate this risk, many noted that a comprehensive approach to raising awareness of PPIUD was required, among all healthcare professionals involved in women’s care antenatally, around birth and postnatally.

Resourcing and sustaining PPIUD services
The cost of PPIUD was perceived as a potential barrier to the sustainability of service provision. Although the long-term benefits of PPIUD were recognised, staff across occupational groups expressed the view that the sustainability of PPIUD provision at vaginal birth was contingent on increased resources to support training, funding for IUD devices, and patient follow-up. Some senior midwives and obstetricians with responsibility for managing maternity budgets highlighted the cost of PPIUD as an issue that could be a drawback for service provision (table 4).

DISCUSSION
A growing body of evidence suggests women desire access to, value and benefit from immediate post-partum contraception; this emphasises the role maternity services can (and should) play in providing contraception prior to discharge. There is limited evidence relating to healthcare professionals’ views, specifically in relation to PPIUD, which requires direct support from maternity professionals to be successful.

Midwives and obstetricians identified PPIUD as a positive development, linking it to ‘holistic’ care for women around the time of childbirth, and reducing barriers to contraceptive access and subsequent intended pregnancy. However, concerns were also
Our findings suggest that many concerns have been identified by staff, particularly midwives, about: role expansion and increased workload; safety of PPIUD; and impact of immediate insertion on mother–baby bonding. Some of these concerns have been identified in other research.7 24 25 Our findings suggest that many concerns dissipate following training in, and practise of, PPIUD. This underscores the importance of evidence-based training, and the challenges for implementing PPIUD when this is lacking.23 26 27 Despite the impact of effective training, some concerns persisted among midwives, highlighting challenges associated with shifting the culture around provision of immediate postpartum contraception, and emphasising the need for continuing education.

In this study the average time between giving birth and insertion was 6.6 hours, with almost one-third (28.2%) of insertions taking place within 1 hour of giving birth and 77.0% within 6 hours.12 As the study progressed, and PPIUD started to become embedded into practice, staff increasingly emphasised the benefits of PPIUD, ideally in the birthing room. Staff recognised that logistical issues (eg, other clinical demands, space and equipment for insertion, and the availability of a trained inserter) impacted on the birth-to-insertion interval time, but highlighted the advantages of shorter intervals for services and women (contributing to a positive PPIUD experience).

Clinician ‘champions’ have been identified as central to shifting cultures around PPIUD.27–30 These are frequently individuals, operating at a local or national level, who demonstrate leadership by extolling the benefits of PPIUD and advancing learning and practice developments. Our findings provide further support for this critical role in shifting mindsets, and...
advocating for the service.

the costs of resourcing PPIUD services (eg, staff training, patient follow-up in primary care settings). Champions can play a leading role in advocating for the service.

CONCLUSIONS

PPIUD in maternity services can help address unmet need for effective contraception in the immediate postpartum period. Changing the hearts and minds of staff towards PPIUD is possible as staff become familiar with the benefits to women and maternity care, and through evidenced-based training. Clinical champions

supporting new services to become established. This shift can encourage more staff to become involved in service delivery, which is important because having a large pool of PPIUD-trained staff was identified as a factor in successful service implementation.

While PPIUD has been demonstrated to be cost effective, there may be concerns around the upfront costs of resourcing PPIUD services (eg, staff training, cost of IUD devices, and patient follow-up in primary care settings). Champions can play a leading role in advocating for the service.

Strengths and limitations

This robust qualitative study, the first of its kind in the UK and Europe, contributes evidence on healthcare professionals’ views on PPIUD. A strength of the study is that it incorporates the views of obstetricians and midwives at different grades, and at different time points, thereby illuminating changes to staff views on

Table 4  Verbatim quotes – staff views on areas for postpartum intrauterine device (PPIUD) service improvement

| Thematic areas                              | Extract                                                                                                                                                                                                 |
|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| **Leading the ‘culture shift’**            | ► “I think that’s just a change in mindset […] that comes from having people in senior roles who are, yeah, championing the cause.” [Trainee Obstetrician]                                                                 |
|                                           | ► “I think even going back a few years when this whole immediate postpartum contraception wasn’t really something that you thought about and I think working with certain Consultant Obstetricians, every single patient I see in antenatal clinic it is a question that comes up now, you know, ‘What about contraception?’ and I think that’s just a change in mindset. But yeah I think that comes from having people in senior roles who are, yeah, championing the cause.” [Trainee Obstetrician] |
|                                           | ► “…things seem to go more smoothly if, as you say, the higher up strategic things are involved in it, you get less people digging their heels in I suppose if it’s come from high, ‘This is an important thing that we all need to do’.” [Consultant Obstetrician] |
| **Reaching a ‘critical mass’ of trained staff** | ► “The gold standard would be to have everybody trained and then it wouldn’t be an issue, they wouldn’t move on [to postnatal ward] without the coil being inserted, it would be inserted with the midwife that was looking after them.” [Trainee Obstetrician] |
|                                           | ► “I think for the postpartum coil because so much timing is around once the baby’s just out, that’s where the training of the right people to get them in, but it will be once you have critical mass in each unit, it’s just getting that critical mass of people who can then train others because you need it to be a 24-hour service.” [Trainee Obstetrician] |
|                                           | ► “…there’ll be a critical mass and once there is enough of us here permanently on the shop floor there’ll always be enough people around to supervise others to learn to then do it, I think it’s just in this initial set up phase when we don’t have enough.” [Trainee Obstetrician] |
| **PPIUD information provision and support** | ► “I think discussion at the antenatal period, I think it needs to start antenatally and certainly the women that have been very keen to have it put in we’ve generally found they’ve been counselled antenatally by the community midwives or by us in clinic here and they’re very up for it before they come to hospital […] I think antenatal education is definitely key.” [Trainee Obstetrician] |
|                                           | ► “I think it has to come from all levels, you’ve got to have, you know, you’ve got to have the awareness it’s going on so everyone’s got to know about it, it’s got to be spread out to the community staff so they’re introducing the idea of it and giving the information antenatally, then the actual staff in the hospital need to know how to go about it, who can do it and then trying to get as many people to do it, so it kinda covers all levels.” [Midwife Group] |
|                                           | ► “…the drawback is that you might then be leaving somebody, you know, it gets expelled and either they haven’t noticed or they haven’t then got the energy or the motivation to go and get something else sorted.” [Consultant Obstetrician] |
| **Resourcing and sustaining PPIUD services** | ► “I think breaking that down and breaking down funding barriers in particular ‘Who’s going to pay for the coils, who’s going to pay for the training?’.” [Consultant Obstetrician] |
|                                           | ► “Maybe as a service provider it could be perceived that initially there might be some negatives in that it’ll come with a cost implication, but in the long term if it avoids these unplanned pregnancies, but it’s that short-term investment for a longer-term gain but sometimes we’re not always very long-sighted, you know, so it could be perceived as a negative because it is going to come at a cost, but hopefully in the long term it will save.” [Midwife Group] |
|                                           | ► “I was going to say about commissioning, about where the funding comes from. So I suspect that a lot of centres will say ‘Well look, this isn’t our remit, we deliver babies here, we don’t stop babies being born’ do you know what I mean, it’s like a bit of a shift from my view of where it’s all part of the process, contraception is part of having a baby, planning your next pregnancy, to people saying ‘That’s nothing to do with us, that’s a completely separate specialty, that’s a completely separate thing’. So I think breaking that down and breaking down funding barriers in particular ‘Who’s going to pay for the coils, who’s going to pay for the training?’.” [Consultant Obstetrician] |

PPIUD, postpartum intrauterine contraception.
and leaders play a key role in amplifying the benefits of PPIUD, and advancing organisational learning.

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REFERENCES
1 Smith GCS, Pell JP, Dobbie R. Interpregnancy interval and risk of preterm birth and neonatal death: retrospective cohort study. BMJ 2003;327:313.
2 Heller R, Cameron S, Briggs R, et al. Postpartum contraception: a missed opportunity to prevent unintended pregnancy and short inter-pregnancy intervals. J Fam Plann Reprod Health Care 2016;42:93–8.
3 Brunson MR, Klein DA, Olsen CH, et al. Postpartum contraception: initiation and effectiveness in a large universal healthcare system. Am J Obstet Gynecol 2017;217:55.e1–55.e9.
4 Jackson E, Glasier A. Return of ovulation and menses in postpartum nonlactating women: a systematic review. Obstet Gynecol 2011;117:657–62.
5 Makins A, Arulkumaran S, FIGO Contraception and Family Planning Committee. The negative impact of COVID-19 on contraception and sexual and reproductive health: could immediate postpartum LARCs be the solution? Int J Gynaecol Obstet 2020;150:141–3.
6 Ogburn JAT, Espey E, Stonehocker J. Barriers to intrauterine device insertion in postpartum women. Contraception 2005;72:426–9.
7 Sonalkar S, Kapp N. Intrauterine device insertion in the postpartum period: a systematic review. Eur J Contracept Reprod Health Care 2015;20:4–18.
8 Faculty of Sexual & Reproductive Healthcare (FSRH). UK medical eligibility criteria for contraceptive use (UKMEC); 2016. https://www.fsrh.org.uk/ukmec/
9 Grimes D, Schulz K, Vän Vliet H. Immediate post-partum insertion of intrauterine devices. Cochrane Database Syst Rev 2003;1:CD003036.
10 Cooper M, Cameron S. Successful implementation of immediate postpartum intrauterine contraception services in Edinburgh and framework for wider dissemination. Int J Gynaecol Obstet 2018;143 Suppl. 1:56–61.
11 Information Services Division (ISD) Scotland. Births in Scottish hospitals: year ending 31 March 2019; 2019. https://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/2019-11-26/2019-11-26-Births-Report.pdf
12 Cooper M, McGeechan K, Glasier A, et al. Provision of immediate postpartum intrauterine contraception after vaginal birth within a public maternity setting: health services research evaluation. Acta Obstet Gynecol Scand 2020;99:598–607.
13 Boydell N, Cooper M, Cameron ST, et al. Women’s experiences of accessing postpartum intrauterine contraception in a public maternity setting: a qualitative service evaluation. Eur J Contracept Reprod Health Care 2020;25:465–73.
14 Heller R, Johnstone A, Cameron ST. Routine provision of intrauterine contraception at elective cesarean section in a national public health service: a service evaluation. Acta Obstet Gynecol Scand 2017;96:1144–51.
15 Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol 2006;3:77–101.
16 Braun V, Clarke V, Hayfield N. ‘A starting point for your journey, not a map’: Nikki Hayfield in conversation with Virginia Braun and Victoria Clarke about thematic analysis. Qual Res Psychol 2019;16:1–22.
17 QSR International Pty Ltd. NVivo (Version 11) [software program]; 2015.
18 Lopez LM, Bernholc A, Hubacher D, et al. Immediate postpartum insertion of intrauterine device for contraception. Cochrane Database Syst Rev 2015;6.
19 Cwiak C, Cordes S. Postpartum intrauterine device placement: a patient-friendly option. Contracept Reprod Med 2018;3:3.
20 Thwaites A, Logan L, Nardone A, et al. Immediate postnatal contraception: what women know and think. BMJ Sex Reprod Health 2019;45:111–7.
21 Thwaites A, Tran AB, Mann S. Women’s and healthcare professionals’ views on immediate postnatal contraception provision: a literature review. BMJ Sex Reprod Health 2019;45:88–94.
22 Scottish Government. Sexual health and blood borne virus framework: 2015–2020 update. Edinburgh: Scottish Government, 2015.
23 Cameron ST, Craig A, Sim J, et al. Feasibility and acceptability of introducing routine antenatal contraceptive counselling and provision of contraception after delivery: the APPLES pilot evaluation. BJOG 2017;124:2009–15.
24 McCance K, Cameron S. Midwives’ experiences and views of giving postpartum contraceptive advice and providing long-acting reversible contraception: a qualitative study. J Fam Plann Reprod Health Care 2014;40:177–83.
25 de Silva R, Huber-Krum S, Samarasekera A, et al. Provider perspectives in implementing the postpartum intrauterine device initiative in Sri Lanka: a qualitative study. BMJ Sex Reprod Health 2020. doi:10.1136/bmjsh-2020-200876. [Epub ahead of print: 19 Nov 2020].

26 Holland E, Michelis LD, Sonalkar S, et al. Barriers to immediate post-placental intrauterine devices among attending level educators. Womens Health Issues 2015;25:355–8.

27 Hofler LG, Cordes S, Cwiak CA, et al. Implementing immediate postpartum long-acting reversible contraception programs. Obstet Gynecol 2017;129:3–9.

28 Okoroh EM, Kane DJ, Gee RE, et al. Policy change is not enough: engaging provider champions on immediate postpartum contraception. Am J Obstet Gynecol 2018;218:590.e1–590.e7.

29 Bonawitz K, Wetmore M, Heisler M, et al. Champions in context: which attributes matter for change efforts in healthcare? Implement Sci 2020;15:62.

30 Harper KD, Loper AC, Louison LM, et al. Stage-based implementation of immediate postpartum long-acting reversible contraception using a reproductive justice framework. Am J Obstet Gynecol 2020;222:S893–905.

31 Washington CI, Jamshidi R, Thung SF, et al. Timing of postpartum intrauterine device placement: a cost-effectiveness analysis. Fertil Steril 2015;103:131–7.