



Feasibility, acceptability and sustainability of postpartum contraceptive implant provision by midwives in NSW public hospitals

Jessica R. Botfield^{a,b,*}, Melanie Tulloch^c, Hannah Contziu^d, Sarah M. Wright^a, Hala Phipps^d, Kevin McGeechan^{a,b,e}, Deborah Bateson^{a,b,e}, Kirsten I. Black^{b,d,e}

^a Family Planning NSW, Ashfield, Australia

^b SPHERE Centre of Research Excellence, Monash University, Australia

^c Canterbury Hospital, SLHD, Australia

^d Royal Prince Alfred Hospital, SLHD, Australia

^e University of Sydney, Australia

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ABSTRACT

Background: Repeat pregnancy in the first year after a birth is common. Many of these conceptions are unintended and may be prevented by providing access to contraception in the immediate postpartum period. Midwives in the hospital setting could potentially play a greater role in improving postnatal contraception information and provision.

Aim: We sought to implement and examine the success of a program training hospital-based midwives in immediate postpartum implant insertion.

Methods: This mixed methods study in two hospitals in New South Wales sought to explore the feasibility, acceptability and sustainability of a program that provided competency-based implant insertion training for midwives. The study documented training completion, implant insertion numbers and experience, and conducted end of study interviews with midwives and stakeholders.

Findings: Twenty-seven midwives undertook training and inserted 265 implants during the study period. Interviews with 13 midwives and 11 stakeholders concluded the program to be feasible and acceptable with midwives reporting high satisfaction from their involvement. All interviewees felt that midwives were well placed to insert implants, and reported that challenges around workload and opportunities for practice were generally manageable. It was recognised that sustainability of the program would require supportive policy and regular insertion opportunities.

Conclusions: Midwives successfully upskilled in implant insertions and there was widespread support for the program with expectations it would be sustained. Provision of contraceptive information and implant insertion by midwives in the immediate postpartum period is likely to increase contraceptive choice and access for women and contribute to reducing rapid repeat pregnancies.

Statement of significance

Problem or issue

Repeat pregnancy in the first year after a birth is common. Discussing and providing contraception in the immediate postpartum period may prevent a short inter-pregnancy interval. Midwives in the hospital setting could play a role in this, however this is not routine practice in Australia.

What is already known

Midwives are well-placed to offer contraception services, and in other countries it is common practice for midwives to insert contraceptive implants.

What this paper adds

Provision of the contraceptive implant by midwives was found to be feasible, acceptable and a potentially sustainable approach. Midwives are well placed to provide the contraceptive implant in the immediate postpartum setting in Australia if trained and

* Corresponding author at: 328-336 Liverpool Rd, Ashfield, NSW 2131, Australia.

E-mail address: jessicab@fpnsw.org.au (J.R. Botfield).

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supported to do so.

Introduction

Many pregnancies in the first year after a birth are unintended [1,2]. Around 40% of Australian women resume vaginal sex within six weeks of birth [3], and those not exclusively breastfeeding can become pregnant from as early as 21 days postpartum [1]. Unintended pregnancies can place significant physical, social and financial strain on women and their families [4,5], and short inter-pregnancy intervals of less than 12 months have a higher association with perinatal complications compared to births after 18 months [6–9]. Access to immediate postpartum contraception can help to avoid an unintended pregnancy [6, 10].

The progestogen implant is a highly effective method of contraception [11]. It can be inserted immediately after birth for women without medical contraindications and is a suitable and safe option for breastfeeding women [12–16]. Insertion of an implant in the immediate postpartum period has been found to be safe, convenient and acceptable and result in high continuation rates [6,17,18]. It also reduces access barriers [1,19,20] compared to postnatal provision in primary care that may necessitate multiple appointments and long waiting times [21,22]. Further, while women are advised to discuss contraception with their general practitioner (GP) at the six-week postnatal check, many either do not attend this appointment or do not have contraception discussed. In addition, there is a lack of evidenced-based guidance on postpartum community care and provision of contraception in Australia [23,24].

As primary maternity caregivers, midwives are well-placed to offer contraception services. In countries such as New Zealand, Sweden and Scotland it is common practice for midwives to insert implants [25–30], however in Australia this is still primarily undertaken by doctors. Expanding the number of clinicians trained in the provision of long-acting reversible contraception (LARC) (i.e. implants and intrauterine devices) is likely to improve equitable access to these reliable contraceptive methods [31–33]. Whilst many midwives in Australia provide contraception information and believe this is an important part of their role, most have not undertaken formal training [34]. Utilising midwives for implant insertions may reduce many of the barriers women experience in accessing this method postnatally. In this study we sought to implement and examine the success of a program training hospital-based midwives in immediate postpartum implant insertion.

Participants, ethics and methods

Design and setting

We undertook a mixed methods study to explore the feasibility, acceptability and sustainability of a program that provided competency-based implant insertion training for midwives. The study took place in one area health service in New South Wales, comprising a large tertiary referral hospital (approximately 5000 births per year [35]) and a smaller metropolitan hospital (approximately 1800 births per year [35]) between March 2019 and June 2021. Drawing on complementary areas of expertise, the multidisciplinary research team was comprised of midwives, clinical academics and reproductive health researchers.

Recruitment

All midwives at each hospital were invited to attend one of seven contraception education sessions run by Family Planning NSW in early 2019 to increase knowledge of contraceptive options and support provision of contraceptive counselling to women. Information about the study was shared during each session to aid recruitment of midwives and advise of future availability of implant insertions by participating

midwives.

All Registered Midwives with an ongoing minimum workload of one shift per week were eligible for the study. Recruitment was led by midwifery members of the research team, educators and managers using email and verbal updates. Participation was offered to the first 30 eligible midwives who consented, to ensure sufficient resources and support could be provided. A midwife from each hospital was a member of the research team and acted as a ‘midwife champion’ to provide local support.

Training and assessment

Participating midwives enrolled in the competency-based “Implanon NXT Insertion and Removal Training Course for Registered Nurses and Midwives” run by Family Planning NSW¹. Midwife champions were trained first and undertook clinical placements at Family Planning NSW to complete ten insertions so they could supervise others. The course combined online theory, a workshop with simulated practice, and supervised practice and assessment. Midwives had to complete two supervised, competent insertions (including a counselling process) to be signed off, and could supervise others after undertaking ten insertions. They accrued Continuing Professional Development hours for the training and received a \$100 gift voucher once accredited. Between May and August 2019, we held six training workshops. The implementation period following training was extended from 6 to 24 months due to the COVID-19 pandemic and associated disruptions.

Study implementation

Contraceptive information was provided to women by midwives and other clinicians antenatally and postnatally, as per routine care. A woman’s intention to have the implant inserted postpartum, if known, was documented in her medical record and the insertion was offered by a trained midwife prior to discharge. A free supply of etonogestrel implants was provided by the study sponsor².

Post-insertion surveys

Midwives completed a post-insertion survey to document each insertion; no identifying patient information was recorded. Results from the post-insertion surveys were summarised using counts and proportions and means and standard deviations where appropriate.

Semi-structured interviews

Participating midwives and stakeholders were invited to participate in an interview between May 2020 and May 2021 (this extended time-frame was due to the COVID-19 pandemic). Interviews were undertaken by members of the research team and explored participants’ views and experiences of the program. Verbal consent was received before each interview.

All interviews were audio-recorded, transcribed verbatim, quality-checked and de-identified, and coded using NVivo software [36]. Following the principles of reflexive thematic analysis [37,38], deductive codes from the interview guides were utilised and built upon with inductive codes derived from line-by-line review of transcripts by author one. Author two coded a selection of transcripts to strengthen the quality

¹ Training was only provided for implant insertion, not removal; women receiving an implant were advised where they could have their implant removed if/when needed.

² At the smaller hospital, if a doctor undertook the insertion (i.e. not as part of the study), the woman was given a script to buy the implant at a pharmacy as per usual practice. At the larger hospital, implants were already available on the ward free of charge, regardless of who inserted them.

and rigour of analysis and to construct and refine themes collaboratively with author one. The number of interviews conducted was based on interest and availability of prospective interviewees, which was made challenging due to the restrictions and demands of the COVID-19 pandemic. Similar patterns of findings were identified among those interviewed, and initial and final themes were discussed and agreed between all authors.

Results

In total, 34 midwives consented to the study.³ Of these, 27 completed the training theory and workshop, and 16 went on to undertake at least one supervised insertion.⁴ All midwives who were deemed competent went on to undertake more insertions (ranging from 2 to 54 insertions,

Table 1
Insertion survey data over 24 months.^a

Survey response options	Smaller hospital (n (%))	Larger hospital (n (%))	Total (n (%))	
Number of insertions	160	105	265	
Were there any delays or barriers in insertion following patient consent? (Yes)	50 (31%)	11 (10%)	61 (23%)	
If yes, reason for delay	Doctor charting Implanon NXT	14 (9%)	3 (3%)	17 (6%)
	Getting the device	1 (1%)	2 (2%)	3 (1%)
	Obtaining local anaesthetic	5 (3%)	0 (0%)	5 (2%)
	Extremely confident	64 (40%)	29 (28%)	93 (35%)
How confident did you feel in undertaking the insertion?	Very confident	72 (45%)	59 (56%)	131 (49%)
	Somewhat confident	20 (13%)	15 (14%)	35 (13%)
	Not so confident	2 (1%)	1 (1%)	3 (1%)
	Not at all confident	0 (0%)	1 (1%)	1 (0%)
	Not answered	2 (1%)	0 (0%)	1 (0%)
Insertion outcome	Straightforward, no issues (Implant in correct position AND easily palpable)	156 (98%)	104 (99%)	260 (98%)
	Implant in correct position but NOT easily palpable	1 (0.6%)	0 (0%)	1 (0.4%)
	Implant NOT in correct location but easily palpable	2 (1%)	0 (0%)	2 (0.8%)
	Not answered	1 (0.6%)	1 (1%)	2 (0.8%)
	Minutes M (SD)	Minutes M (SD)	Minutes M (SD)	
Time for consent process immediately prior to insertion	7 (6.2)	9 (6.8)	8 (6.5)	
Time for actual insertion procedure	15 (8.7)	8 (5.2)	12 (8.1)	

^a Includes both supervised and independent insertions.

³ Four late sign-ups were included beyond the agreed limit of 30 as some consented midwives were unable to attend the training workshop.

⁴ Seven of the 34 midwives did not participate as they were not available for any workshops. Eleven midwives who completed the workshop did not undertake any implant insertions; several reasons for this are reported in the paper, for the three midwives who completed an interview.

with a mean of 17), apart from one who left employment. Eight midwives completed more than 10 insertions during the study period and were able to supervise colleagues. Midwives working primarily on a postnatal ward or in a clinical education role inserted the highest number of implants. In total, midwives inserted 265 implants during the study period, with no major adverse events reported (Table 1). On three occasions when the implant was not easily palpable at the end of the procedure or not in the correct location, midwives consulted with a colleague (midwife champion or doctor) and it was determined no further management was needed.

Interviews were conducted with 13 midwives, including the two midwife champions, and 11 stakeholders: three doctors (staff specialists and residents), four midwifery managers, three pharmacists and a clinical midwifery specialist. Three overarching themes are reported here, pertaining to the feasibility, acceptability and sustainability of implant insertions by midwives in the immediate postpartum period.

Feasibility

Both midwives and stakeholders discussed various factors regarding the feasibility of midwives inserting the contraceptive implant in the postpartum period.

Midwives raised time constraints as a key challenge, not only for the procedure itself but also for ensuring informed consent. All midwives indicated they provided counselling prior to insertion, with the depth and duration varying depending on the woman’s existing knowledge and interest. The process took longer than anticipated on occasions when an implant had been charted but the woman had not received sufficient information, or an interpreter was required. It was apparent that the more insertions midwives completed, the more confident they felt and the quicker the overall process became.

“(Sometimes) it can be like a bit of a burden, like to be honest with you. Because you’re so, like balancing your own workload and then you have to do this extra bit” (M10)
 “(The informed consent process) really varies... I always start by going in and having that counselling discussion first. I don’t just go in with all my clinical equipment” (M12)
 “...the girls did get quicker at them but they’re really setting aside half an hour/40 minutes to do the counselling and the insertion and the aftercare... they get quicker as they get further along but they’ve all been very prudent about doing really thorough counselling as well” (S09; midwifery manager)

Midwives highlighted limited access to supervision, and not having regular opportunities to insert, as challenges to gaining and maintaining skills and confidence. This posed a greater challenge in the larger hospital where fewer midwives were trained and therefore fewer supervisors were available, and for midwives who did not regularly work on the postnatal ward; for example, those who worked irregular shifts, in multiple wards, or in continuity of care models such as midwifery group practice.

“I guess the barrier for us has been that, if I care for four women a month and none of them are interested in Implanon, that’s a whole month that I’m going without being accredited or doing one and you become rusty very quickly” (M08)
 “Probably the most important things are ensuring the midwives can keep inserting them on a regular basis. The times when I ticked ‘less confident’ on the survey have been when I haven’t done one for a month or so. And it’s just like riding a bike. I feel a bit unsure, at first, and then it all comes back” (M12)
 “You don’t learn everything in just one fell swoop, you know. You tend to learn a little bit and then the next time you learn a little bit more and a bit more. So I think it’s just that learning on the job and just the feel of it. The more you do the better you get at it” (M09)

Despite these challenges, most midwives felt they were able to manage this and make time for insertions. They highlighted the appropriateness of midwives providing this service due to their accessibility and flexibility. Many reported having multiple conversations with women over their shift to facilitate informed decision-making, and felt they were generally able to undertake insertions at a time that suited the midwife, mother, and supervisor if one was needed, including timing this around women's other care needs and feeding times. Most felt they were able to meet the demand for implants, reporting it was rare that a woman wanting an implant would be discharged without one.

"...we give 24-h care, why not do it at 2 o'clock in the morning if she's awake, like, especially for postnatal women, they're awake at all hours of the day" (M03)

"(Doctors are) running around doing other things and I think it makes it then hard for them to like run in and insert an Implanon and then run back out, whereas a midwife who is working on the ward with that woman or with that load of women is much more accessible" (M02)

"(Midwives) have the most face-to-face time with the women so it's the perfect opportunity to get to talk to them about this... Even continuity within an eight-hour shift in comparison to a doctor, sometimes they'll come in and they'll see them for 10 minutes" (M11)

"I've done a couple on nightshift because women are awake, breast feeding 24 hours a day, so it was convenient for them to have one at 1am. And that was really awesome that I could provide that... it meant that they got home at 10am the next morning which is when they wanted to leave" (M12)

Acceptability

Postpartum implant provision by midwives was acceptable to midwives themselves, to other medical staff, and to women. Whilst initial resistance from some midwives and doctors due to workload issues and scope of practice concerns was raised, this appeared to diminish over the study period.

"...at the beginning I think there was quite a bit of resistance and not wanting to increase the workloads, and I think that was a big concern" (M13)

"I know there was some resistance initially from quite high up medicos because it was a doctor's job; the perception was this was the role of the doctor" (S09; staff specialist/resident)

The program overall was highly regarded by all as an important service that led to an improvement in the quality of contraception discussions and increased access to contraception. Many felt there had been an increase in demand for the implant since the study started, which they attributed to easier access to the device (see theme 3) and a clinician to insert. The positive impact on women was reiterated throughout interviews.

"I think midwives are more inclined to have a more in-depth conversation about (contraception)... they know about the study and they know what's happening on the ward. And they want to give that woman every opportunity to avail of it if she wants to... I just think since we've been doing this study, it's kind of brought it to the forefront a bit more" (M09)

"...it's cool to streamline patient care, and to be able to get things done quickly and efficiently; which often means that if midwives can work to their full scope of practice it means that it improves the quality of patient care that they get, and they don't end up hanging around for doctors" (M07)

"It's a fabulous way to improve access to postpartum contraception... so women don't have to wait around for one single resident who's taking care of a whole ward or even two wards, to put one in. It

also lets the primary clinician in the woman's care be the one doing it... There's more midwives than there are junior doctors on the ward, so it does increase accessibility and reduces wait time overall" (S07; staff specialist/resident)

The perceived acceptability among women was identified by midwives and stakeholders as being underpinned by a familiarity with and trust in midwives.

"...a lot of women have commented that it's nice that the midwives can provide this service for them. And that a woman, who they know and had developed a certain degree of trust in, can have these sensitive discussions with them" (M12)

"I would argue that it's seen as more acceptable to the women because it's done by someone who's a familiar face; they've looked after them for the shift or the shift before. So it's more accessible, more acceptable..." (S09; midwifery manager)

Medical staff were also supportive as the program increased access for women and facilitated the sharing of workload. The only reported disadvantage of the program by a doctor interviewed was the potential for reduced experience for junior medical staff.

"I find, actually, the doctors are really supportive of women having Implanons and of midwives putting them in... I think they want women to have contraception and they don't mind how they get it" (M05)

"I didn't put any Implanon's in last year, and I'm okay with that. But it would have helped with just my training so I feel like I am a bit deskilled, as a result" (S07; staff specialist/resident).

The interest and enthusiasm from participating midwives was raised as an important element of acceptability by stakeholders and was similarly highlighted in comments from midwives. Whilst several participants from the larger hospital felt a lack of interest from some midwives may be a barrier in providing the service more broadly, most felt there was high interest overall.

"...there'll always be midwives out there who just don't think it's important or aren't motivated. But I think that's a minority of midwives... they're realising they would like to increase their own knowledge of it and that they think it's really important for women" (M12)

"The enabler was just really the interest and the energy of the midwives" (S09; midwifery manager)

Interviewees also commented that implant insertions were a relevant and important skill for midwives from both a personal and professional perspective; it enhanced job satisfaction, enabled more autonomy, and provided an additional skill for professional portfolios. Most participating midwives appeared to experience great satisfaction in practicing this extended skill and offering women a service they felt they may otherwise miss out on.

"I think it's a great opportunity for midwives... inserting Implanon for women is a way that I can still feel like I'm practicing autonomously, even though the doctor's charting it" (M03)

"I think I, personally, have found it rewarding just, because it's an additional clinical skill... I found it very satisfying to be a midwife who's able to do a skill that's one the doctors don't actually have themselves... I think it's just been nice to have a skill that is in a way, respected as a doctor-level skill... I think it's (also) just been really positive because it gives women choice" (M12)

"I think midwives, when you work in a ward environment, you want to find your niche. This will all go towards things like a CMS portfolio for a midwife... it gave them some autonomy within their role on the unit here" (S09; midwifery manager)

Sustainability

The majority interviewed expressed a desire for the program to continue and shared suggestions for how it could be improved and sustained. This included the importance of having a policy and governance structure in place to support implant insertion training and supervision, as well as the value of having educators or a champion to drive and support the service.

“And certainly the midwives want it to continue. And I have a list of people who are keen to do the next available workshop... so I really hope that we can get support and the clinical governance framework in place to continue this in our local health district even after the study finishes” (M12)

“...we have to ensure that our midwives are firstly backed by policy to be able to do this but secondly receive the appropriate training and supervision” (S10; midwifery manager)

Several stakeholders suggested having more midwives accredited to insert implants would also help to meet demand and reduce the workload of current inserters. This was felt to be an enabling factor at the smaller hospital, where more midwives participated and were accredited relatively quickly. Prioritising the training of midwives on the postnatal ward to insert implants was deemed most appropriate, although a small few queried whether provision may also be appropriate during postnatal home visits.

“...it would've been better if there were more core midwives who were accredited... the risk is that you put a lot of time into it and those midwives that are accredited aren't available” (S06; midwifery manager)

“The question I really ask is how can we, if ever, make it something they could do at home... Is there a community nurse functionality within midwifery where the Implanons could be inserted at home?... relying on that woman to then go to the GP at six weeks, that's just flawed... I think the continuity models probably are in a better position to do it” (S09; midwifery manager)

Participants also felt that providing regular contraceptive education or collegial de-briefing sessions for both midwives and doctors would be of value to increase knowledge and support.

“...it would be really great to have some sessions where we get together and we talk about... what we're coming across, and how we, the words we use to women... sharing all sorts of things about any difficulties we have, any tips, things we've found” (M05)

“...midwives want to be talking more about contraception but often just lack more detailed knowledge about particular methods. Someone who's able to offer regular education to midwives, that would be really helpful... That could probably be delivered in-house, in form of further in-services for example... even for the midwives who don't actually want to physically insert Implanon, I think a lot of midwives would like to improve, at least, their knowledge of contraception and ability to provide counselling” (M12)

“I don't think that Implanon is offered very commonly at the moment, and that's just part of how postnatal care happens. I think that educating doctors could also have an effect of increasing that, if it was built into hospital protocols that women should have a discussion around contraception, including Implanon, then the junior medical staff could have a role in that as well” (S02; staff specialist/resident)

As contraceptive implants were supplied for the study, concerns were raised about availability once the study ended, particularly at the smaller hospital which did not stock the implant at either the hospital or local pharmacy. Whilst the implant was available in the larger hospital pharmacy, participants also noted the importance of having imprest stock on the ward to increase access. The need to identify women in the

antenatal period and provide a script (if desired) for early purchase was highlighted.

“I think how we get the Implanons and how we put them in for women, so where they're stored, who orders them... that's going to take some working out” (M05)

“...there's possibly one or two Implanon on the ward, so I guess as imprest stock [at larger hospital]. So possibly a bit limited by what is, what's on the imprest depending on how many you need... when it's ordered from pharmacy, as you know it doesn't necessarily get to the ward straightaway” (S04; pharmacist)

“...it just makes it harder for, for it not to be stocked... (if) you purchase it antenatally, it might make...the transition a bit smoother from offering it to actually putting it in” (S07; staff specialist/resident)

Finally, many interviewed expressed that postpartum implant insertions by midwives could become ‘part of the norm’, and that this normalising would enable more time to be allocated for insertions within a midwife's workload.

“(Midwives inserting) could just become the norm at (smaller hospital) so easy. I think actually it's already the norm and we will really miss it if it stops once the study finishes... I think midwives should take a lead role in contraceptive counselling and insertion... It should be a normal part of the care we provide in hospitals, and midwives should be integral in that” (M05)

“...once it becomes part of what's considered normal practice, it can then be factored into the timeframe that midwives are given to spend with women” (S10; midwifery manager)

Discussion

Provision of the contraceptive implant by midwives was found to be feasible, acceptable and a potentially sustainable approach for enhancing access to this method in the postpartum period. All midwives accredited in insertions with ongoing employment undertook additional insertions and felt confident in doing so with no major adverse events reported, suggesting midwives are able and willing to continue this practice independently. Whilst several challenges were raised, including workload and opportunities for practice, most midwives were able to manage these and reported high satisfaction with the program. Midwives and stakeholders felt the study had made a positive impact on women by improving the quality of contraception discussions and increasing access to the contraceptive implant, and had contributed to increased job satisfaction and professional development for midwives. It was clear that ongoing sustainability of the program would require a supportive policy and regular insertion opportunities for midwives.

The workload implications for midwife provision of postpartum implants should not be underestimated, as has been identified elsewhere [39–41]. However, this did not deter midwives interested in providing this service, particularly those working on the postnatal ward or in a clinical education role who had more opportunity to access supervision and insert regularly. Most midwives valued the opportunity and felt they were in an appropriate position to provide this service due to their accessibility, flexibility and relationship with women. A UK study exploring the views of postnatal women and midwives regarding provision of contraceptive advice and methods similarly found both supported this option, with women citing convenience and a trusting relationship as reasons for preferring midwifery provision over visiting a doctor [41]. It was clear from our study findings that increasing the number of midwives accredited in implant insertions will improve access to supervision and share the insertion workload. Whilst midwives and educators working on the postnatal ward may be particularly well-suited to providing postpartum insertions, consideration of different models of midwifery care, such as midwifery group practice,

will be important when determining training priorities. Extending standing orders for midwifery prescription of the contraceptive implant may also further streamline the process, given the primary delay midwives identified was waiting for doctors to chart the device.

To facilitate postpartum contraception decision-making and uptake, antenatal contraceptive counselling and planning for postnatal provision is essential [42]. Findings from this study highlight the importance of providing information both antenatally and postnatally, as has been suggested in other studies [41,43–48], to lay the groundwork for decision-making and increase access. In-hospital postpartum contraception provision can encourage patients and staff to talk about contraception [49], as was found in our study, and contraception education sessions for clinicians would further facilitate this. This would also be beneficial in midwifery training programs to increase contraception knowledge of graduating midwives [34]. These efforts would be well supported by a postpartum contraception clinical practice guideline; whilst this does not currently exist in the Australian context, it would be a valuable tool to promote high standards of consistent contraceptive care to all women after birth [23].

We acknowledge several limitations of our study and opportunities for further research. The midwives and stakeholders interviewed were involved in or closely familiar with the study, so ours was likely a biased sample. Midwives not involved in the study were not invited to interview. All interviews were conducted by members of the research team, most of whom also worked at the participating hospitals, which may have limited open discussion for some. However our findings are not too dissimilar to other overseas findings [41]. Further research should explore the impact such a program has on reducing short inter-pregnancy intervals. Research exploring the feasibility and acceptability of midwifery-provided implant insertions in different postpartum settings, including during postnatal home visits (particularly in relation to local anaesthetic use), as well as in regional and rural hospitals, would also be of value.

Conclusion

Findings from our study suggest that midwives, if trained and supported, are well placed to provide the contraceptive implant in the immediate postpartum setting. Midwives were successfully upskilled in implant insertions and there was widespread support for the program with expectations it would be sustained. For this to continue, midwives must be supported by hospital policy that recognises this as part of their scope of practice and encourages training and practice opportunities.

In addition, clinicians working in antenatal and postnatal roles should also be offered contraception education to increase knowledge and confidence in discussing options with women.

Routine contraceptive counselling, along with the option of implant provision by midwives, will increase contraceptive choice and access to postpartum contraception, and support women in planning potential subsequent pregnancies. Task-sharing with midwives may also reduce pressures on hospital medical staff and reduce primary care workload in the community. With a supportive policy, practice opportunities and an enabling environment, implant insertions by midwives could become the norm in Australian hospitals and improve access to this method of contraception for women.

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Ethical statement

Ethics approval was received from the Sydney Local Health District RPAH (approval # X18-0314) and Family Planning NSW (approval # R2018-05) Human Research Ethics Committees.

Author contributions

- Jessica Botfield: Conceptualization, Methodology, Funding acquisition, Project administration, Investigation, Data curation, Formal analysis, Writing - original draft.
- Melanie Tulloch: Investigation, Data curation, Formal analysis, Writing - original draft.
- Hannah Contziu: Investigation, Data curation, Writing - review & editing.
- Hala Phipps: Conceptualization, Methodology, Investigation, Writing - review & editing.
- Sarah Wright: Project administration, Data curation, Writing - review & editing.
- Kevin McGeechan: Conceptualization, Methodology, Formal analysis, Writing - review & editing.
- Deborah Bateson: Conceptualization, Methodology, Writing - review & editing.
- Kirsten Black: Conceptualization, Methodology, Investigation, Writing - review & editing.

Conflicts of interest

B and KB have attended advisory meeting(s) for Merck Sharp & Dohme / Organon as representatives of Family Planning NSW and RANZCOG respectively. No personal remuneration was received. No other conflicts to declare.

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